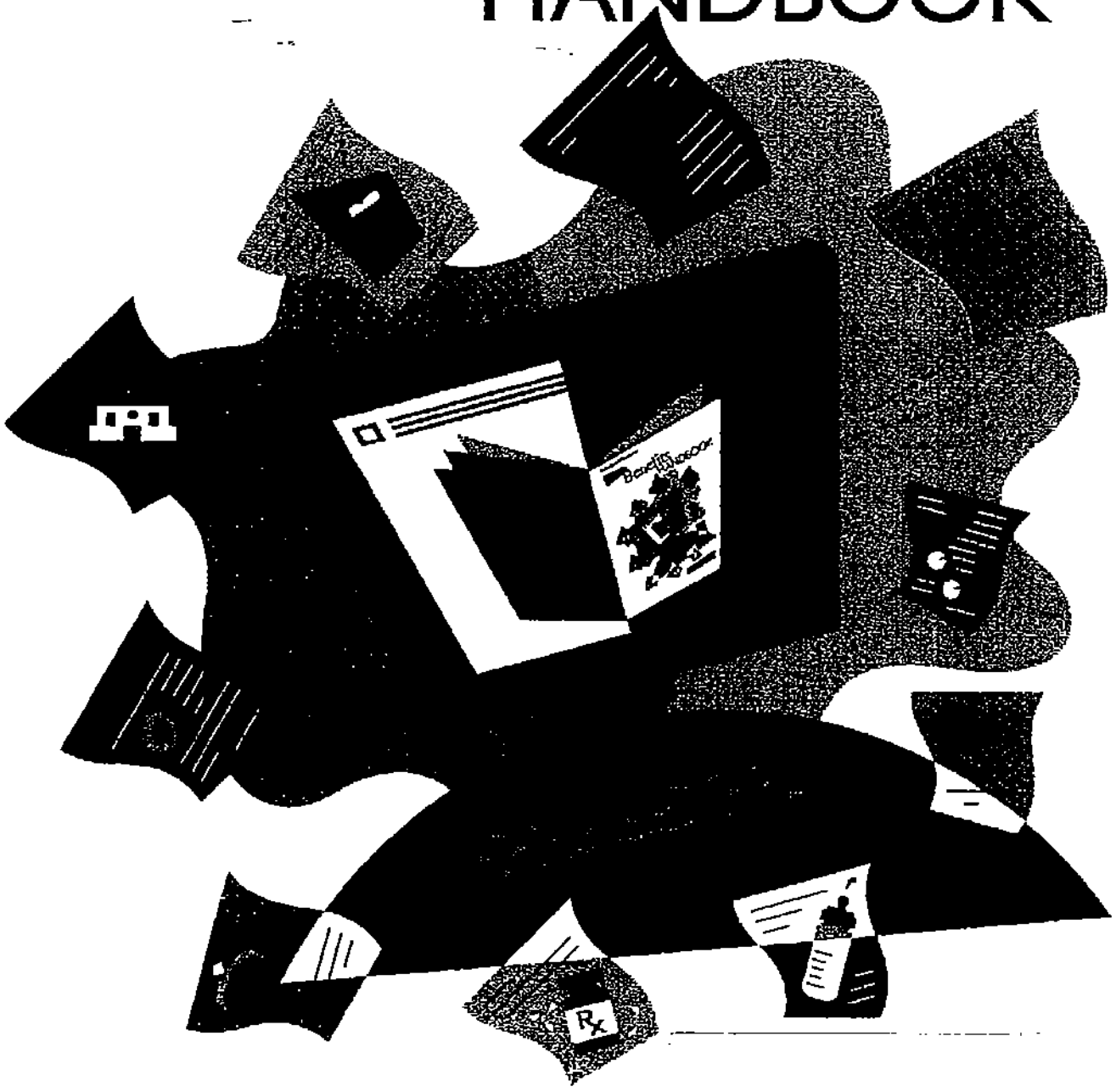
Exhibit E (1 of 3)

The McGraw-Hill Companies

YOUR Benefits HANDBOOK



The McGraw-Hill Companies

YOUR Benefits HANDBOOK

Effective
January 1, 2004

Contents

About This Handbook

The McGraw-Hill Companies, Inc. (also referred to in this handbook as "The McGraw-Hill Companies" and "the corporation") provides a broad range of competitive benefits for its employees and their eligible family members. This handbook summarizes the key provisions of the benefit plans to help you use them most effectively. The handbook also alerts you to actions that could limit the benefits you and your eligible family members might receive.

This handbook is designed with a number of features to help you find the answers you are looking for and has been written, as much as possible, in simple, straightforward language, so that it is easy to understand.

About Summary Plan Descriptions

The U.S. Department of Labor requires that employers provide employees with "Summary Plan Descriptions" (SPDs) of certain benefit plans. This handbook is designed to serve as the primary part of the Summary Plan Description for the corporation's benefit plans. For some of the healthcare plans, there are two other documents that complete their SPDs:

- the *Healthcare Option Summaries* and
- the documents prepared by certain medical plans that contain additional coverage details for those plans. (These documents are included primarily to provide the required level of detail about insured HMOs offered by the corporation.)

This handbook, the *Healthcare Option Summaries*, and the documents containing additional coverage details are all available online at *www.benefitsplanner.com*. Online users may also print these documents from the Web site by:

- using the *Easy Print* link on the handbook site,
- using the browser's print function for the *Healthcare Option Summaries*, and
- printing the additional coverage details, which are provided as Adobe Acrobat PDF files, using Acrobat Reader.

Print copies of these materials are also available upon request from the Human Resources Service Center (HRSC) at 1-888-THE-HRSC (1-888-843-4772).

This handbook, the *Healthcare Option Summaries*, and the documents containing additional details prepared by certain medical plans provide you with most of the information you will need about the benefits offered under each of The McGraw-Hill Companies, Inc. benefit plans. However, the SPD provides only a summary of these benefits and does not cover all of the details. The details are provided in the official plan documents for each plan, including, if applicable

- the plan document,
- collective bargaining agreements,
- insurance contracts, and
- the trust agreement pursuant to which the assets of the plan are held.

If you have questions about any plan or would like to review these documents, please call the Human Resources Service Center (HRSC) or see the procedures described in the *Rules and Regulations* section. In the event that there is an inconsistency between any of the terms of the official plan documents and this handbook, the *Healthcare Option Summaries*, or the documents containing additional details prepared by certain medical plans, the official plan documents will prevail.

The portions of the handbook that relate to the 401(k) savings and profit sharing plans and the *Rules and Regulations* section (to the extent it relates to these plans) constitute part of a prospectus covering securities that have been registered under the Securities Act of 1933 (Section 428(b) of the Securities Act of 1933).

Trademarks

The names of actual companies and products mentioned in this SPD and/or third party trademarks, trade names and logos contained herein may be the trademarks of their respective owners.

About the Benefit Plans

Please note that the corporation has the right, with or without advance notice, in an individual case or generally, to amend or terminate all or any part of the benefit program, your contributions to it, or those who participate in it, at any time and for any reason, at its discretion, subject to any collective bargaining agreement when appropriate.

The Board of Directors of The McGraw-Hill Companies, Inc. (or its designee) has the authority to adopt or terminate all benefit plans and may delegate its authority. The Board of the plan sponsor, the CEO Council, and the person in the position of Executive Vice President, Human Resources (or equivalent position) may modify and amend any of the benefit plans. The Pension Investment Committee of The McGraw-Hill Companies, Inc. has responsibility for managing the assets of the Retirement Program plan trusts. The plan administrator is responsible for filing all returns, reports, and notices required by ERISA.

Updated Information

This handbook supersedes all earlier descriptions of the plans, as of January 1, 2004.

Because the benefits may change, the corporation will provide you with updated information as necessary. You will be notified of any material reduction in covered services under the healthcare plans within 60 days after the change is adopted.

The easiest way to get the most current information on your benefit plans is to use the online version of the handbook, which will be updated regularly.

About Your Employment

This handbook is for your information only; it is not a binding contract, and it is not meant to impose any legal obligation upon you or the corporation. Nor do the benefits provided by the plans and programs described in this handbook imply or create a binding contract of employment between the corporation and any employee. No one is authorized to provide any employee with an employment contract concerning the terms or conditions of employment unless the contract is in writing and signed by an authorized corporate representative. Employment with the corporation is "at will" and may be terminated at any time, with or without cause or notice, by the employee or the corporation, except as provided by the terms of any applicable written employment contract or collective bargaining agreement. This provision applies to all employees regardless of the first date of employment.

At a Glance

This section contains brief "at a glance" summaries for all of the benefit plans described in this handbook.

Additional Information

Be sure to review the *Rules and Regulations* section for additional important information about the corporation's benefits and your rights.

In This Section **See Page**

Healthcare

Participating in Healthcare Coverage at a Glance

Employee Eligibility	▪ To participate, you must be an active employee who is regularly scheduled to work 20 or more hours a week for a business unit that participates in the corporation's benefits.
Spouse Eligibility	▪ If you are an eligible employee and are married, your spouse is eligible: – for medical coverage as your dependent, – for dental coverage as your dependent, – for vision coverage as your dependent, and – for continued healthcare coverage under COBRA. ▪ In addition, your spouse is eligible – to have eligible healthcare expenses reimbursed through your healthcare flexible spending account and – to be insured through the corporation's dependent life and accident insurance plans. ▪ Your spouse may not enroll for disability insurance through the corporation's plans.
Eligibility for Adults Other Than a Spouse	▪ If you are an eligible employee and are not married or do not wish to enroll your spouse, you may enroll one other adult for most of the healthcare plans. The adults eligible to be enrolled include: – your domestic partner (you must provide an affidavit confirming the relationship) – your or your spouse's: ♦ parent, ♦ grandparent, ♦ sibling, or ♦ adult child age 23 or older. ▪ Remember, you may cover *only one adult other than yourself*, even if more than one adult family member would meet the requirements for eligibility. Also, be aware that some of the plans do not allow coverage for all of these adults, generally because the plans are subject to approval by state insurance boards that do not have such broad eligibility rules. If you want to cover one of these adults, check the descriptions of each plan carefully, to see whether the plan provides coverage for that individual in your state.
Eligibility for Your Dependent Children	▪ If you are eligible, you may cover your dependent children under the same plans offering coverage for employee spouses. (If you have enrolled your domestic partner, you may cover your domestic partner's dependent children as well as your own dependent children.) Eligible dependent children can include your (or your enrolled domestic partner's) children who: – are under age 23, – are not married, – are not employed on a full-time basis, – are dependent on you for financial support, and – either: ♦ live with you, or ♦ are away at school. ▪ Eligible children include: – children by birth, – children by adoption (effective as of the date the child is placed for adoption), – stepchildren, and – children for whom you (or your domestic partner) are legally responsible.

Enrolling	▪ Coverage is not automatic—you must enroll to have coverage. The enrollment choices you make stay in effect for the full calendar year. ▪ If you enroll for coverage within 31 days of becoming eligible, the coverage is effective as of the first day you were eligible. – If you do not enroll within 31 days, you will not have another opportunity to enroll until the next annual enrollment period, unless you have a qualifying change in status. ▪ For each healthcare benefit you enroll in you must select a coverage level: – Employee only. – Employee plus one eligible family member. – Employee plus two or more eligible family members.
Paying for Coverage	▪ The corporation pays most of the cost of your medical and dental coverage. Your share of the total cost generally depends on: – your salary (for medical coverage only), – the coverage option you choose, and – the level of coverage you select. ▪ In most cases, you pay your contributions for medical, dental, and vision coverage through payroll deductions using pre-tax dollars.
Changing Your Benefits	▪ Because contributions to healthcare plans use pre-tax dollars, federal regulations limit when you can make changes. In general, you can make changes to your participation in these plans only: – during the annual benefits enrollment period (when you make enrollment choices for the next calendar year), – if you have a qualifying change in status, such as getting married or divorced or having a baby (when you can make changes that must be consistent with the change in status), or – if you lose other coverage that was in effect during the last annual benefits enrollment period.

For more information, see Participating in Healthcare Coverage.

Medical Coverage at a Glance

Your Medical Options	▪ Depending on where you live, you are able to choose from the following types of medical coverage: – UnitedHealthcare Point-of-Service (POS) plan—The POS plan is available in most areas. – Health Maintenance Organizations (HMOs)—The HMO options available to you vary depending on where you live. HMO plans are available in most areas. – A traditional medical indemnity plan, The McGraw-Hill Companies Medical Plan—This plan is offered only in areas where the POS plan is not available. ▪ Alternatively, you may waive medical coverage.

For more information, see Your Medical Options.

Point-of-Service Plan at a Glance

How the POS Plan Works	▪ Each time you need care, you decide whether to use POS plan network physicians or to get care from a provider outside the network—the POS plan provides coverage both in- and out-of-network. – When you use network providers, benefits are generally higher and your out-of-pocket expenses are lower. – When you use network providers, you usually pay only a fixed fee, called a copayment, for outpatient care. You do not need to file claims. – For in-network hospitalization, surgical and diagnostic service expenses, you pay a percentage of the cost, which is your coinsurance. The plan reimburses a portion of your covered medical expenses. The reimbursement is usually 90% of the reasonable and customary cost. – If you use out-of-network providers, you pay the full cost of your care when you receive it and then must file a claim to receive benefits from the plan. For out-of-network care, the plan reimburses a portion of your covered medical expenses after you meet an annual deductible. The reimbursement is usually 70% of the reasonable and customary cost. ▪ When you enroll, you select a primary care physician (PCP) who is responsible for coordinating the care you get from network providers. – The POS plan allows you to see a network specialist without a referral from your PCP or any other network approval.
In-Network Benefits	▪ You receive in-network benefits if your care is coordinated by your PCP (or if you follow any alternative guidelines the POS plan provides for receiving in-network care). – Your PCP provides basic medical services, including preventive care. – If you need specialized care, you can see a network specialist without getting a referral from your PCP. ▪ For specific copayment amounts, see the POS plan summary at *www.benefitsplanner.com* or in the *Healthcare Option Summaries*.
Out-of-Network Benefits	▪ You may go to a provider who is not part of the network at any time. ▪ Out-of-network care is covered at a lower level than in-network care. ▪ When you go to an out-of-network provider, you are responsible for paying the full cost of your care and must submit a claim for benefits. ▪ The plan pays benefits after you have paid a certain amount of your annual medical expenses, called your deductible. – Once you satisfy the deductible, the plan pays a percentage (usually 70%) of the eligible charges based on reasonable and customary (R&C) fee schedules. This is called coinsurance. ▪ When your out-of-pocket expenses, exclusive of any deductibles and charges in excess of R&C charges, reach a certain limit for the year, you have met your out-of-pocket maximum. – After you reach the out-of-pocket maximum, the plan pays 100% of the eligible charges for out-of-network services for the rest of the year. (There may be exceptions for prescription drug benefits and for mental health/chemical dependency care.) You continue to be responsible for any charges in excess of R&C schedules. ▪ For certain kinds of care you may need to notify the plan in advance. Contact UnitedHealthcare POS Plan at 1-866-328-6575. ▪ For specific deductible and coinsurance information, see the POS plan summary at *www.benefitsplanner.com* or in the *Healthcare Option Summaries*.

Filing a Claim	▪ If you receive in-network care, you don't have to file a claim. ▪ If you receive out-of-network care, you generally pay the full cost of your medical expense at the time you receive care, then submit a claim for benefits. In some cases, you can have the plan reimburse your provider directly. ▪ Claim forms for all plans are available: – on The McGraw-Hill Companies Intranet, – on the Web at *www.benefitsplanner.com*, – from the HRSC at 1-888-THE-HRSC (1-888-843-4772), and – from UnitedHealthcare POS Plan at 1-866-328-6575. ▪ If you're enrolled in a Healthcare FSA and the UnitedHealthcare POS Plan, your unreimbursed medical claims will be submitted automatically for reimbursement.

For more information, see Point-of-Service (POS) Plans.

HMO Coverage at a Glance

How the Typical HMO Works	▪ When you need care, you must receive that care from a provider who is part of your HMO's network. HMOs generally do not cover care you receive from providers outside the network (with some exceptions for emergency care). ▪ You usually pay only a fixed fee, called a copayment. You do not need to file claims. ▪ When you enroll, you select a primary care physician (PCP) who is responsible for coordinating the care you get from network providers. ▪ To see a specialist, even a specialist who is part of your HMO's network, most HMOs require that you get a referral from your PCP or have other network approval. If you don't have a referral or other approval, the specialist care may not be covered by the plan. ▪ Specific benefits vary depending on the HMO you select. You can find more information about the HMOs available to you at *www.benefitsplanner.com*, in the *Healthcare Option Summaries*, or by contacting the HRSC.
Primary Care Physicians (PCPs)	▪ You select one physician—your PCP—to provide your routine and preventive care. Your PCP coordinates all your healthcare, generally referring you to specialists when necessary. ▪ Your options for choosing a PCP depend on the plan you select. You can find PCPs listed in the HMO's provider directory or through The McGraw-Hill Companies Intranet. ▪ You may select a different PCP for each covered family member.
Copayments	▪ You pay a small fixed fee, called a copayment, whenever you visit a doctor. ▪ Office visits to either your PCP or to a network specialist with a PCP referral are usually covered at 100% after you pay a copayment.

For more information, see Health Maintenance Organizations (HMOs).

Traditional Indemnity Plans at a Glance

How The McGraw-Hill Companies Medical Plan Works	▪ This plan is available only to employees in locations with limited managed care options. ▪ The plan has no network—you may use any provider you choose. ▪ You pay the full cost of your care when you receive it, and then must file a claim to receive benefits from the plan. ▪ The plan reimburses a portion of your covered medical expenses (based on reasonable and customary fee schedules) after you meet an annual deductible.
Annual Deductible	▪ Each year, you must pay a certain amount of your expenses before the plan pays benefits. This is called meeting your annual deductible. ▪ For plan deductible amounts, see the plan summaries at *www.benefitsplanner.com* or in the *Healthcare Option Summaries*.
Coinsurance	▪ Once you meet the deductible, the plan pays 80% of the cost for most eligible expenses. You pay the remaining 20%, called your coinsurance. All reimbursements are subject to reasonable and customary limits. ▪ For plan coinsurance amounts, see the plan summary at *www.benefitsplanner.com* or in the *Healthcare Option Summaries*.
Advance Notification	▪ You must notify Care Coordination in advance before receiving certain kinds of healthcare. Call Care Coordination at 1-866-328-6575.
Out-of-Pocket Maximum	▪ The out-of-pocket maximum is the limit that you and your family have to pay for eligible expenses in a year. It's designed to protect you from having to pay extraordinary medical bills in a given year. Once your expenses reach the out-of-pocket maximum, the plan pays 100% of eligible charges for the rest of the calendar year.
Filing a Claim	▪ You must pay the bill at the time you receive care and file a claim form for reimbursement. ▪ Claim forms for all plans are available: – on The McGraw-Hill Companies Intranet, – on the Web at *www.benefitsplanner.com*, – from the HRSC at 1-888-THE-HRSC (1-888-843-4772), and – from your plan at the number on your ID card. ▪ If you're enrolled in a Healthcare FSA and The McGraw-Hill Companies Medical Plan, your unreimbursed medical claims will be submitted automatically for reimbursement.

For more information, see Traditional Indemnity Plan.

Prescription Drug Coverage at a Glance

How Prescription Drug Benefits Work	▪ All the corporation's medical options include prescription drug coverage. Your prescription drug benefits depend on: – the plan you select, – whether the prescribed drug is on the plan formulary, – whether you purchase generic or brand-name drugs, and – whether you fill your prescription in-network, out-of-network (for certain plans), or by mail. ▪ Prescription drug benefits for the UnitedHealthcare POS Plan, the Aetna (Self-Insured) HMO, and The McGraw-Hill Companies Medical Plan are administered by Medco Health. The HMOs administer thier own prescription drug programs. ▪ When you enroll for medical coverage, you may receive a separate ID card for prescription drug coverage. You will need to present this card at the time you fill your prescription. ▪ For the specific prescription drug benefits of each plan, see the plan summaries at *www.benefitsplanner.com* or in the *Healthcare Option Summaries*.
Generic vs. Brand-Name Drugs	▪ In most plans, you will save on out-of-pocket costs if you have your prescriptions filled with generic, instead of brand-name, drugs.
Formulary Drugs	▪ A formulary is the list of drugs the medical plan recommends for most prescriptions. Formulary lists are based on proven treatment effectiveness, cost compared with other medications, and other factors.
Mail-Order Prescriptions	▪ If you have a chronic condition that requires ongoing medication, you may have access to a mail-order program that can provide you with a long-term supply of prescription drugs. Examples of chronic conditions include arthritis, high blood pressure, diabetes, and allergies. ▪ In the POS plan, mail-order services are only covered in-network.

For more information, see Prescription Drug Coverage.

Mental Health/Chemical Dependency Coverage at a Glance

Coverage Options	▪ You have two options when you or a covered family member needs mental health/chemical dependency care: – The Employee Assistance Program (EAP), which is a free, confidential counseling service that is available to all employees, even if you do not elect medical coverage from the corporation. See *Employee Assistance Program* in *Other Benefits* for information. – The mental health/chemical dependency benefits that you receive when you enroll for coverage from one of the medical options offered through the corporation.
Coverage Through Your Medical Plan	▪ The plan summaries show the specific mental health/chemical dependency benefits offered through each medical plan, including any copayment or deductible amounts. View your plan summary at *www.benefitsplanner.com* for specific information.

For more information, see Mental Health/Chemical Dependency Coverage.

Dental Coverage at a Glance

How The McGraw-Hill Companies Dental Plan Works	▪ This is a traditional indemnity plan that reimburses a portion of your covered dental expenses. For certain services, you must meet an annual deductible before the plan pays benefits. ▪ The plan has a discount feature called the Dental Preferred Provider Organization (Dental PPO). With the Dental PPO, you receive a discount when you use dental care providers who are in the PPO network. – You are not required to use the PPO network. With The McGraw-Hill Companies Dental Plan, you always have the option to use the dentist of your choice. ▪ A detailed description of The McGraw-Hill Companies Dental Plan is available online at *www.benefitsplanner.com* or in the *Healthcare Option Summaries*.
How the DMO Dental Plan Works	▪ The DMO provides dental care through a network of dentists and other dental care providers. You are not eligible for any benefits under this plan when you use providers who are not part of the DMO network. ▪ If you enroll in the DMO and use dentists in its network for your care, your out-of-pocket dental costs will generally be lower than with The McGraw-Hill Companies Dental Plan. ▪ If you need to see a specialist, your DMO dentist must give you a referral or you will not receive benefits—even if the specialist participates in the DMO network. ▪ A detailed description of the DMO Dental Plan is available online at *www.benefitsplanner.com* or in the *Healthcare Option Summaries*.
Filing a Claim	▪ For the McGraw-Hill Companies Dental Plan, you pay the full cost of your dental expense at the time you receive care, then submit a claim for reimbursement. You can print claim forms using The McGraw-Hill Companies Intranet, or online at *www.benefitsplanner.com*. You can also get forms by calling the HRSC. ▪ For the DMO Dental Plan, you don't need to file claims when you use your DMO dentist for your dental services.

For more information, see Dental Coverage.

Vision Coverage at a Glance

How the Vision Plan Works	▪ The plan covers services and materials from providers and eyewear facilities that participate in the Vision Service Plan (VSP) network. ▪ The plan pays the entire cost of covered services and materials. However, there are frequency limits. ▪ You are responsible for any cosmetic options you choose and for any non-covered services and materials. ▪ For specific plan details, see the plan summary at *www.benefitsplanner.com* or in the *Healthcare Option Summaries*.
Finding a VSP Provider	▪ To find a VSP-participating provider in your area: – Call VSP at 1-800-VSP-7195 (1-800-877-7195). – Visit *www.vsp.com*. – E-mail VSP at member@vsp.com. – Access VSP through The McGraw-Hill Companies Intranet. ▪ To locate a VSP doctor who participates in the laser vision correction surgery program: – Call 1-888-354-4434. – Visit *www.vsp.com*.

For more information, see Vision Coverage.

Retiree Healthcare Coverage at a Glance

Eligibility	▪ If you are enrolled in corporation-provided medical, dental or vision coverage when you retire, you can enroll in the same type of coverage if you meet one of the following requirements: – You are age 55 or older with at least 10 years of continuous service and are eligible for a pension plan (ERP) benefit from the corporation. – You are age 50 or older with at least 20 years of continuous service and are terminated through no fault of your own. ▪ If you are covering any eligible family members on the day before you retire, you may continue their coverage if you enroll for retiree coverage.
Enrolling	▪ You must enroll within 31 days of your retirement, or you will not be able to obtain retiree healthcare coverage from the corporation at a later date.
Paying for Coverage	▪ Your contributions for coverage depend on: – when you retired, – your service with the corporation prior to your retirement, and – the healthcare options and level of coverage you select: ♦ self only, ♦ self plus one eligible family member, or ♦ self plus two or more eligible family members. ▪ You pay for retiree medical, dental and vision coverage with monthly contributions. These contributions can be deducted from your monthly pension check. ▪ When the corporation's share of retiree medical costs reaches two times its 1993 cost, the corporation's contribution to pay for coverage will not increase any further. If retiree medical coverage costs continue to increase, retirees will be responsible for all costs beyond the corporation's contribution.
Retiree Healthcare Options	▪ There are three medical options available to eligible retirees who are younger than age 65 when they retire: – Health Maintenance Organizations (HMOs)—If an HMO is available in your area, you can choose this option. – Point-of-Service (POS) Plan—If an HMO is not availalbe in your area, you may choose the POS plan. You may also "buy up" to the POS plan if both an HMO and the POS plan are available in your area. – The McGraw-Hill Companies Modified Medical Plan (traditional indemnity plan)—If you live in an area where there is no HMO or POS coverage offered by McGraw-Hill, you can enroll in The McGraw-Hill Companies Modified Medical Plan. ▪ At age 65, you become eligible for Medicare, and Medicare becomes your primary coverage. You may supplement Medicare with corporation-provided prescription drug coverage by participating in The McGraw-Hill Companies Drug Supplement Plan. ▪ If you are eligible for retiree healthcare coverage, you can continue the same dental coverage that you had on your last day as an active employee when you retire from the corporation. ▪ If you are eligible for retiree healthcare coverage and if you were enrolled in the Vision Plan on your last day as an active employee, you can continue that same coverage when you retire from the corporation.

For more information, see Retiree Healthcare Coverage.

Expatriate Coverage at a Glance

Expatriate Medical Coverage	▪ Medical coverage for expatriates is provided through the Global Choice plan, which is a health care alliance between BUPA International and UnitedHealthcare. Information is available by: – Calling +44 (0) 1273-773-736 – E-mailing choiceinfo@bupa-intl.com – Visiting *www.bupa-intl.com/membersworld*
Expatriate Dental Coverage	▪ Expatriates can participate in The McGraw-Hill Companies Dental Plan or the DMO Dental Plan. However, the DMO Dental Plan network only includes providers in the United States.

For more information, see Expatriate Healthcare Coverage.

COBRA Coverage at a Glance

Eligibility	▪ If your healthcare coverage ends because you no longer meet the eligibility requirements or experience another COBRA qualifying event, you may continue this coverage under COBRA. ▪ Your covered family members also may continue healthcare coverage under COBRA if your eligibility ends, or if the family member experiences a COBRA qualifying event, even if your coverage does not end. For example: – Your spouse can elect COBRA health coverage if you get divorced or legally separated. – Your dependent children who lose eligibility through a change in age or marital, educational, or employment status can elect COBRA health coverage. ▪ While covered under COBRA, you must notify the HRSC within 31 days after any change in status if you want to make a change in coverage, such as enrolling a new child for COBRA coverage. See "Changes in Status" in *COBRA Health Coverage*. ▪ You may be eligible to extend your COBRA health coverage if you become disabled while you are covered through COBRA. Notify the HRSC within 60 days of being determined totally disabled by the Social Security Administration.
Enrolling	▪ If you are eligible, you must elect COBRA health coverage within 60 days after the event that qualifies you for COBRA coverage. If you miss the 60-day deadline, you cannot enroll. ▪ If a covered family member's coverage ends (such as in the event of a divorce; legal separation or if a dependent child becomes ineligible for corporation healthcare benefits), you are responsible for notifying the HRSC within 60 days, so the person losing coverage can elect COBRA health coverage.
Your COBRA Health Coverage Options	▪ If you are eligible for COBRA coverage, you may continue coverage under any of the following healthcare plans that covered you at the time your corporation coverage ended: – Medical – Dental – Vision ▪ Employees who were contributing to a Healthcare FSA may continue to contribute, but only on an after-tax basis and only until the end of the calendar year in which you become eligible for COBRA. If you do this, there is no tax advantage for the new contributions, but you extend your access to the funds already in your account. Remember that you may file claims only for eligible expenses that were incurred while you were contributing. See "Continuing Contributions—COBRA" in *Healthcare FSA*.
How Long Coverage Lasts	▪ You can continue health coverage through COBRA for up to 18, 29, or 36 months, depending on how you or your family member becomes eligible.
Cost of COBRA Coverage	▪ If you continue coverage, you will pay the full cost of coverage (your contributions, plus the share of the cost that had been paid by the corporation), plus a 2% administrative charge. Special rules apply if you become disabled.

For more information, see COBRA Health Coverage.

Flexible Spending Accounts

Participating in Flexible Spending Accounts at a Glance

Separate FSAs	▪ The corporation offers two kinds of FSAs—a Healthcare FSA and a Dependent Care FSA. ▪ You can use the money in a Healthcare FSA to pay for eligible healthcare expenses, and the money in a Dependent Care FSA to pay for eligible dependent day care expenses. The two accounts are not interchangeable.
Eligibility	▪ To participate, you must be an active employee who is regularly scheduled to work 20 or more hours a week for a business unit that participates in the corporation's benefits.
Enrolling & Changing Participation	▪ Participation is not automatic—you must enroll to participate. The enrollment choices you make stay in effect for the full calendar year. ▪ If you enroll in either FSA within 31 days of becoming eligible, your participation is effective as of the first day you were eligible. – If you do not enroll within 31 days, you will not have another opportunity to enroll until the next annual enrollment period, unless you have a qualified status change. See *Participating in Healthcare Benefits* for more information. ▪ Each year, the corporation holds an annual enrollment period, during which you can enroll in the FSAs for the next calendar year. In most cases, the annual enrollment period is the only time when you can enroll (if you did not enroll when first eligible). – If your family status changes during the year (for example, if you get married or have a baby), you can make changes consistent with your change in status, such as changing your contribution level or enrolling in an FSA if you are not already enrolled.

Healthcare FSA at a Glance

Whose Expenses Are Eligible	▪ You can use your healthcare FSA to reimburse eligible healthcare expenses incurred for: – you, the eligible employee, – persons you claim as dependents on your federal tax return (whether or not they are eligible for, or covered by, any of the corporation's healthcare plans), and – dependent children who do not live with you, if you are legally required to pay their healthcare expenses. ▪ You may not use a Healthcare FSA for your former spouse's expenses. ▪ If you have a domestic partner, you may use a Healthcare FSA to reimburse yourself for your partner's eligible expenses only if he or she is your tax dependent.
How the Healthcare FSA Works	▪ You set aside money from your paycheck on a pre-tax basis (thereby reducing your taxable income) to pay for eligible healthcare expenses incurred by you and/or your eligible family members. ▪ After incurring eligible expenses, you submit a claim that is reimbursed from your account. ▪ Your Healthcare FSA claim for eligible expenses is paid in full—up to the amount of your annual healthcare contribution—regardless of how much you have in your Healthcare FSA at the time you submit your claim. (Reimbursements are paid differently under the *Dependent Care FSA*.) ▪ Each year, you receive a statement showing your Healthcare FSA balance and any payments made from your account. ▪ By year-end, if you haven't incurred enough eligible expenses to use up the money remaining in your Healthcare FSA, you forfeit that money. You have until March 31 to submit claims for eligible expenses incurred through December 31 of the previous year. ▪ You may only be reimbursed for healthcare expenses incurred while you are contributing to the Healthcare FSA.

How Much You Can Contribute	▪ You can set aside up to $5,000 per full calendar year in the Healthcare FSA (with an annual minimum of $50). Your contributions are automatically deducted from your pay on a pre-tax basis and redirected into your account in equal amounts throughout the year. ▪ If you begin participating midway through the calendar year, the amount you can contribute will be prorated. For example, if you do not open an account until July 1, you would be permitted to contribute only $2,500 (half of the $5,000 allowed per full calendar year) over the remaining half of the year.
Filing Claims	▪ You have until March 31 of the following calendar year to submit claims for expenses incurred during the current calendar year. ▪ Claim forms are available: – at myuhc.com, – on The McGraw-Hill Companies Intranet, – on the Web at *www.benefitsplanner.com*, – from the HRSC, and – from UnitedHealthcare at 1-877-211-6551. ▪ If you enroll in the Healthcare FSA and either the UnitedHealthcare POS Plan or The McGraw-Hill Companies Medical Plan, your unreimbursed medical claims will be submitted automatically for reimbursement, since UnitedHealthcare also administers the corporation's FSAs.
Continuing Participation	▪ If your participation in the Healthcare FSA ends (for example, if your employment ends), you may be eligible to continue making contributions to the FSA on an after-tax basis through the end of the calendar year under the provisions of COBRA. If you have a significant balance in your account, continuing to make contributions can give you time to incur eligible expenses and file claims to be reimbursed, rather than forfeiting the account balance.

For more information, see Healthcare Flexible Spending Accounts.

Dependent Care FSA at a Glance

Whose Expenses Are Eligible	▪ You can use the Dependent Care FSA to reimburse eligible dependent care expenses for the care of: – children under age 13 whom you can claim as dependents on your federal income tax return, – a disabled spouse who is physically or mentally incapable of self-care, and – any other person whom you can claim as a dependent on your federal income tax return and who is physically or mentally incapable of self-care. ▪ Remember, your dependents' healthcare expenses are eligible for reimbursement through a separate account, the Healthcare FSA.
What Care Is Eligible	▪ The Dependent Care FSA can be used to help cover the cost of care for eligible dependents (as noted above) so that you can work. If you are married, the dependent care must be necessary: – so that your spouse can work also or look for work, – so that your spouse can attend school full time, or – because your spouse is disabled. ▪ Eligible expenses include the following: – Licensed nursery schools and day care centers for preschoolers, as well as summer day camps for children under age 13. (Schools and centers must comply with state and/or local laws and receive a fee for their services.) – Services from persons who provide day care in or outside your home, except when the provider is your dependent or your child under age 19 – Day care centers that provide nonresidential day care for dependent adults – Household services related to the care of an elderly or disabled adult who lives with you – FICA and other taxes you pay on behalf of a day care provider

How the Dependent Care FSA Works	▪ You set aside money from your paycheck on a pre-tax basis (thereby reducing your taxable income) to pay for eligible dependent care expenses you incur so you can work. ▪ After incurring eligible expenses (and paying the care provider), you submit a claim that is reimbursed from your account. ▪ Your claim for eligible expenses is paid up to your account balance at the time you submit the claim. If you ask to be reimbursed for an expense that is greater than the amount in your account, the excess expense is carried over until you have sufficient funds in your Dependent Care FSA to cover it during that calendar year. (Reimbursements are paid differently under the *Healthcare FSA*.) ▪ Each year, you receive a statement showing your Dependent Care FSA balance and any payments made from your account. ▪ By year-end, if you haven't incurred sufficient eligible expenses to use up the money remaining in your Dependent Care FSA, you forfeit that money. You have until March 31 to submit claims for eligible expenses incurred through December 31 of the previous year. ▪ You may be reimbursed for eligible dependent care expenses incurred through December 31 of the year for which you established the FSA.
How Much You Can Contribute	▪ You can set aside up to $5,000 (with an annual minimum of $50) per full calendar year in the Dependent Care FSA. Your contribution is automatically deducted from your pay on a pre-tax basis and redirected into your account in equal amounts throughout the year. ▪ If you are married, the most you and your spouse can contribute to Dependent Care FSAs is $5,000 per year. If you are married and file your tax return separately from your spouse, the most you can contribute is $2,500. Other limits may apply, especially if your spouse does not work. ▪ If you begin participating midway through the calendar year, the amount you can contribute will be prorated. For example, if you do not open an account until July 1, you would be permitted to contribute only $2,500 (half of the $5,000 allowed per full calendar year) over the remaining half of the year.
Filing Claims	▪ You have until March 31 of the following calendar year to submit claims for expenses incurred during the current calendar year. ▪ Claim forms are available: – on *myuhc.com*, – on The McGraw-Hill Companies Intranet, – on the Web at *www.benefitsplanner.com*, – from the HRSC, and – from UnitedHealthcare at 1-866-328-6575.

For more information, see Dependent Care Flexible Spending Account.

Disability Coverage

Participating in the Disability Plans at a Glance

Eligibility and Enrolling	▪ You are eligible for the STD Plan and for the LTD Plan if – you are an active full-time or an active part-time employee, – you are regularly scheduled to work at least 20 hours per week, and – you are employed in the United States, or you are a U.S. employee temporarily working abroad. ▪ You are automatically enrolled for STD coverage and for basic LTD coverage on the first day you are eligible. ▪ If you enroll within 31 days of becoming eligible for the LTD Plan, you can enroll for supplemental coverage without providing medical evidence of insurability. Otherwise, evidence of insurability is required before supplemental coverage can begin. ▪ You are not eligible for STD, basic LTD, or supplemental LTD coverage if you belong to one of the groups listed under "Individuals Not Eligible" in the *Rules and Regulations* section.
Your Cost of Coverage	▪ The corporation pays the full cost of your STD and basic LTD coverage. ▪ If you enroll for supplemental LTD coverage, you pay for your coverage through after-tax payroll deductions. The premium is based on the amount of your supplemental benefit as a percentage of your eligible compensation.

For more information, see Participating in the Disability Plans.

Short-Term Disability Coverage at a Glance

How the STD Plan Works	▪ You can receive up to 26 weeks of payments from the STD Plan: – The Salary Continuation portion pays 100% of your compensation for a period of time determined by your length of service. – The Accident and Sickness portion pays two-thirds of your compensation when your salary continuation benefits end. ▪ When calculating the length of time for which you can receive 100% of your compensation, all your absences during the current calendar yera up to the first day you are disabled are counted against the total time period. ▪ The benefits you receive from the STD Plan are taxable. This means all income and Social Security (FICA) taxes are withheld from your benefits payment. ▪ Any scheduled pay increase that would become effective while you are disabled is deferred until you return to work.
Receiving Benefits	▪ If you are absent from work due to an illness lasting fewer than six days, you automatically receive STD benefits without having to file a claim. ▪ If you are absent due to an illness lasting for more than five consecutive working days, or due to an accident or hospitalization lasting a day or more, and you are under a physician's care, you need to notify your supervisor immediately and Contact Liberty Mutual at 1-800-853-7109.
Amount of Your Benefit	▪ The amount of your benefit depends on your continuous service. – If your continuous service is less than five months, you receive 100% of your compensation for up to two weeks. – If your continuous service is five months or more but less than four years, you receive 100% of your compensation for four weeks. – If your continuous service is four years or more, you receive 100% of your compensation for six weeks, plus 2 additional weeks for each additional year of service, up to a maximum of 26 weeks.
How Long STD Benefits Continue	▪ Your STD benefits end on the earliest of the following dates: – The date you recover (that is, the date you no longer meet the STD Plan's definition of disability, and your approved disability ends) – The date you return to work (or if you are on maternity leave, the date you begin to use your vacation time or begin an unpaid FMLA leave) – The date you do not provide proof of your disability or other information when requested by the corporation – The date you stop receiving reasonable and appropriate medical treatment for your disability, as determined by the corporation – The date the 26-week benefit period ends and LTD benefits may begin (different provisions apply in California) – The day you die
What's Not Covered	▪ The STD Plan does not cover disabilities that are – related to your job, – the result of war or international armed conflict, – the result of an intentionally self-inflicted injury, while sane or insane – incurred during the commission of a felony or while engaging in an illegal operation, or – the result of cosmetic surgery.

For more information, see Short-Term Disability Coverage.

Long-Term Disability Coverage at a Glance

How the LTD Plan Works	▪ The LTD Plan can pay a benefit if you are totally disabled as defined by the LTD Plan and unable to work for more than 26 weeks. The plan offers two levels of coverage: – Basic coverage, which is automatic and paid for by the corporation, providing you with up to 50% of your compensation, up to a maximum of $10,000 per month. – Supplemental coverage, which is purchased at your expense, providing you with up to a combined benefit (including the basic LTD benefit) of 66⅔% of your compensation, up to a maximum of $20,000 per month. ▪ For both basic and supplemental LTD coverage, your eligible compensation is limited to a maximum of $360,000 per year. ▪ If you are eligible for other disability benefits, your benefits from the corporation may be reduced.
Receiving Benefits	▪ Benefits are paid only if you are totally disabled as defined by the LTD Plan. The definition of totally disabled changes after you have been receiving LTD benefits for 24 months. ▪ How long benefits can continue also depends on your age when your disability begins: – If you become disabled before age 60, benefits can continue to age 65. – If you become disabled at age 60 or older, benefits can continue for up to five years.

For more information, see Long-Term Disability Coverage.

Other Disability Plans at a Glance

Workers' Compensation	▪ You are eligible for Workers' Compensation coverage if you are an active employee working in the United States. ▪ Workers' Compensation can provide you with income when a job-related illness or injury prevents you from working. ▪ Coverage varies by state and is provided at no cost to you.
Social Security Disability Benefits	▪ You may be eligible for Social Security disability benefits if your disability – has lasted at least five months, and – is expected to last at least 12 months. ▪ Social Security can provide you with these two types of disability benefits: – Primary benefits, which are paid to you – Family benefits, which are paid to you for your family members ▪ The amount of your benefit depends on your employment history. For specific information, contact your local Social Security Administration office.

For more information, see Other Disability Coverage.

Life and Accident Insurance

Life Insurance Coverage at a Glance

Your Life Insurance Options	▪ The corporation automatically provides free basic life insurance coverage equal to one times your total annual compensation, up to $100,000. If your annual compensation is more than $50,000, you have the option to limit your basic life insurance coverage to $50,000 to avoid taxes on the value of coverage above $50,000, which IRS rules consider to be "imputed income." – Employees who were employed with the Broadcasting group as of December 31, 2003 may have slightly different coverage, continued from a Broadcasting plan that is no longer open to new participants. ▪ You may purchase additional coverage, as follows: – Choose coverage for yourself of one, two, three, four, or five times your annual compensation, rounded to the next higher $500, up to a maximum of $2 million. – Choose coverage for your spouse up to $100,000 in $10,000 multiples. – Choose coverage for your eligible dependent children equal to $5,000 or $10,000 for each child. ▪ For children from ages 14 days to six months, the maximum benefit payable is $500, regardless of the amount of coverage you choose. The full coverage amount you select goes into effect when your child reaches six months of age.
Eligibility	▪ You are eligible for life insurance coverage if – you are employed by a business unit that participates in the applicable plan, – you are an active full-time or part-time employee, – you are regularly scheduled to work at least 20 hours per week, and – you are employed in the United States, or you are a U.S. employee temporarily working abroad. ▪ Your spouse and eligible dependent children also are eligible for life insurance coverage if they meet the requirements defined under "Eligibility and Enrolling" in *Life Insurance Coverage*. – Your spouse must be your legal spouse according to the laws where you live and must be under age 70. – Children must be at least 14 days old and younger than age 23 ▪ Domestic partners, their children, and other adult family members are not eligible for life insurance coverage.
Enrolling	▪ If you are eligible, basic life insurance coverage is automatic, and begins on the first day you are eligible. There is no need to enroll and no evidence of insurability is required, but you do need to name a beneficiary. ▪ You may enroll for supplementary life insurance as of the first day you are eligible. If you enroll for coverage of less than $250,000, coverage begins the first day you are eligible, provided you are actively at work on that day and you enroll within 31 days of the date you became eligible. Otherwise, coverage begins when the insurance company approves your application, provided you are actively at work on that day. ▪ If you are eligible, you may enroll your spouse and eligible dependent children, respectively, for spousal and children's life insurance coverage at any time. Coverage begins when the insurance company approves your application. ▪ You can begin the enrollment process by calling the Human Resources Service Center (HRSC) at 1-888-THE-HRSC (1-888-843-4772).

Evidence of Insurability	▪ You can enroll for supplementary life insurance without providing evidence of insurability if: – you enroll within 31 days of becoming eligible, and – you enroll for coverage of less than $250,000. ▪ If you do not meet both of the requirements above, you must always provide evidence of insurability to elect supplementary life insurance. ▪ Evidence of insurability is required for all spousal life insurance coverage. ▪ You can enroll your eligible children for life insurance coverage without providing evidence of insurability if you enroll within 31 days of becoming eligible or during an annual enrollment period.
Paying for Coverage	▪ The corporation pays the full cost of your basic life insurance. ▪ You pay for any supplementary, spousal, and children's life insurance through after-tax payroll deductions. ▪ If you are eligible to continue participating in a corporation plan when you are not an active employee, you must make arrangements through the HRSC to pay any required contributions directly to the corporation.
How Benefits Are Paid	▪ Life insurance benefits are paid to the beneficiary on record in one lump sum.
Filing a Claim	▪ To file a claim, notify the Human Resources Service Center (HRSC) at 1-888-THE-HRSC (1-888-843-4772). A representative will explain the benefits that are provided and what is needed to process the claim. ▪ If you or your spouse is to receive benefits from this plan, you must file a written claim with the insurance company. In the case of your death, your manager notifies the HRSC and the HRSC contacts the beneficiary on file.

For more information, see Life Insurance Coverage.

Accident Insurance at a Glance

Your AD&D Options	▪ You may purchase employee AD&D insurance coverage equal to one to 10 times your annual compensation, rounded to the next higher $10,000, up to a maximum of $750,000. ▪ If you purchase AD&D insurance coverage for yourself, you may purchase – spousal AD&D insurance coverage up to $300,000 in $25,000 increments, and/or – children's AD&D insurance coverage equal to either $10,000 or $20,000 for each eligible child.
Eligibility	▪ You are eligible to enroll for AD&D insurance coverage if – you are employed by a corporation business unit that participates in the applicable plan, – you are an active full-time or part-time employee, – you are regularly scheduled to work at least 20 hours per week, and – you are employed in the United States, or you are a U.S. employee temporarily working abroad. ▪ Your spouse and eligible dependent children also are eligible for AD&D insurance coverage if they meet the requirements defined under "Eligibility and Enrolling" in *AD&D Insurance Coverage*. – Your spouse must be your legal spouse according to the laws where you live and must be under age 70. ▪ Domestic partners, their children, and other adult family members are not eligible for AD&D insurance coverage.
Enrolling	▪ You may enroll for AD&D coverage as of the first day you ar eligible or at any time after that. ▪ If you are eligible, you may enroll your spouse and eligible dependent children, respectively, for spousal and children's AD&D insurance coverage at any time. ▪ You can begin the enrollment process by calling the Human Resources Service Center (HRSC) at 1-888-THE-HRSC (1-888-843-4772).

Paying for Coverage	▪ You pay for AD&D coverage for yourself, your spouse and your eligible dependent children through after-tax payroll deductions. ▪ If you are eligible to continue participating in a corporation plan when you are not an active employee, you must make arrangements through the HRSC to pay any required contributions directly to the corporation.
How Benefits Are Paid	▪ The plan pays the full benefit amount in case of accidental death—this is also known as the "death benefit." Partial benefits are paid for certain covered accidental dismemberments. In case of accidental death, benefits are paid to the beneficiary on record. In case of accidental dismemberment, benefits are paid to the insured person. Payment is usually made in one lump sum, but installments can also be arranged.
Filing a Claim	▪ To file a claim, notify the HRSC by calling 1-888-THE-HRSC (1-888-843-4772). A representative will explain the benefits that are provided and what is needed to process the claim. If you or your spouse is to receive benefits from this plan, you must file a written claim with the insurance company. In the case of your death, your manager notifies the HRSC and the HRSC contacts the beneficiary on file.
Executive 24-Hour AD&D Insurance	▪ A group of McGraw-Hill executives at grade level 23 and above or the equivalent are eligible for this plan. If you are eligible, you will be notified. ▪ If you are eligible for this plan, you are not eligible for coverage under the Group Travel Accident Insurance Plan's coverage for employees at or below salary level 22. ▪ There's no need to enroll for this plan; participation is automatic. ▪ The program covers you for three times your annual salary, up to a maximum of $1 million in the event of your death or dismemberment resulting from any accident occurring at any time.

For more information, see AD&D Insurance Coverage.

Travel Accident Insurance at a Glance

Eligibility and Enrolling	▪ All active employees at salary grade level 22 and below are eligible for travel accident insurance. ▪ There's no need to enroll for this plan; participation is automatic. However, you must name a beneficiary who will receive your travel accident insurance benefits if you die as the result of a covered accident. ▪ If you are an executive at salary level 23 or above, you are not eligible for the coverage for employees at or below salary level 22. Instead, you have coverage under the Executive 24-Hour AD&D Insurance Plan.
Amount of Your Benefit	▪ The corporation automatically provides you with coverage equal to five times your annual compensation, rounded to the next higher $500, with a minimum death benefit of $50,000 and a maximum of $1 million.
How Benefits Are Paid	▪ The plan pays the full benefit amount (also known as the "death benefit") in case of accidental death or certain covered losses while traveling on business for the corporation. A percentage of the death benefit is paid for certain covered losses. ▪ Death benefits are paid to the beneficiary on record. In case of accidental dismemberment, benefits are paid to you. Payment is usually made in one lump sum, but installments can also be arranged.
Filing a Claim	▪ To file a claim, notify the Human Resources Service Center (HRSC) toll-free at 1-888-THE-HRSC (1-888-843-4772). A representative will explain the benefits that are provided and what is needed to process the claim. If you or your spouse is to receive benefits from this plan, you must file a written claim with the insurance company. In the case of your death, your manager notifies the HRSC and the HRSC contacts the beneficiary on file.

For more information, see Travel Accident Insurance.

Retirement Benefits

The 401(k) Savings Plan at a Glance

Eligibility	▪ Generally, you are eligible to participate in the plan if you are an active employee working in the United States or are an active U.S. employee temporarily working abroad.
Enrolling	▪ When you become eligible, you are automatically enrolled in the 401(k) savings plan. – Contributions equal to 3% of your eligible pay will be deducted from your pay approximately 60 days after your hire date and will be invested in the Retirement Asset Fund III. – You can change your contribution rate and your investment choices at any time. ▪ If you do not wish to participate in the 401(k) savings plan, you must contact HR Solutions @ccess and change the 3% contribution rate to 0%.
Your Contributions	▪ Through payroll deductions, you can contribute any whole percentage up to 25% of your eligible compensation, subject to IRS limits and plan limits. – You may make contributions on a tax-deferred basis or on an after-tax basis, or as a combination of both. ▪ You can change your contributions at any time and your investment elections daily, by visiting HR Solutions @ccess through The McGraw-Hill Companies Intranet or on the Internet at *www2.benefitsweb.com/mgh.html*, or call HR Solutions @ccess at 1-800-358-3603. – Transactions entered by 4:00 p.m. on the 15th of the month will be effective the first of the following month and will be reflected in the first semi-monthly payroll of the month. – Transactions entered after 4:00 p.m. on the 15th of the month and before 4:00 p.m. on the last day of the month will be effective the 16th of the month following and reflected in the second semi-monthly payroll of the month. ▪ IRS annual maximums and plan contribution limits may affect how much you can contribute.
Catch-Up Contributions	▪ If you will be age 50 or older in 2004, you may be eligible to make additional pre-tax contributions to your 401(k) account, called "catch-up" contributions. For more information, see "Employee Contributions" in *401(k) Savings Plan*. ▪ Your catch-up contributions will be invested with your regular 401(k) contributions.
Corporation Matching Contributions	▪ The corporation matches the first 6% of your tax-deferred contributions to the plan. – The corporation matches the first 3% you contribute dollar for dollar. – The match on the next 3% you contribute is 50¢ on the dollar.
When Contributions Vest	▪ You are always vested in your own contributions and the earnings on them. ▪ You are immediately vested in any corporation matching contributions made after December 31, 2000. ▪ Any unvested corporation matching contributions made before January 1, 2000 will vest in accordance with a four-year schedule (25% per year). For more information, see "Vesting" in *401(k) Savings Plan*.
Investing Your Savings	▪ You decide how the money in your 401(k) savings plan account is invested, choosing from among 10 investment funds and allocating your savings in whole percentages.
When You Can Receive a Distribution	▪ The 401(k) savings plan is designed to help you save for your retirement. You are eligible to receive a distribution of your account balance: – when you retire, – if you become totally disabled, or – when you leave the corporation. ▪ Your beneficiary is entitled to a distribution in the event of your death. ▪ You can withdraw after-tax portion of your savings up to two times a year.

Hardship Withdrawals and Hardship Loans While You Are Still Working	▪ In certain approved situations of financial hardship, you may be able to access your tax-deferred savings before retirement. ▪ In exchange for the special tax advantages you receive as a 401(k) savings plan participant, certain restrictions and tax penalties may apply.
Your Beneficiary	▪ When you enroll, you name a beneficiary to receive your plan balance in the event of your death. ▪ If you are married, your spouse is automatically your beneficiary. ▪ To change your beneficiary, complete and submit a new form. Forms are available by visiting HR Solutions @ccess online through The McGraw-Hill Companies Intranet or by calling HR Solutions @ccess at 1-800-358-3603.

For more information, see 401(k) Savings Plan. *For more information on investing, see* Investment Options. *For more information on taxes, see* Taxes.

The Profit Sharing Plan at a Glance

Eligibility and Enrolling	▪ Generally, you are eligible to begin participating if: – you are at least 21 years old, – you have at least one year of continuous service, and – you are an active employee working in the United States or an active U.S. employee temporarily working abroad. ▪ You automatically become a plan participant on the first day of the month coinciding with or following the month in which you become eligible.
Corporation Contributions	▪ The corporation may make a contribution to your profit sharing account each year.
Investing Your Profit Sharing Account	▪ You decide how the money in your profit sharing plan account is invested, choosing from among 10 investment funds and allocating your savings in whole percentages.
When Your Benefits Are Vested	▪ You are fully vested in the corporation's contributions and the earnings on them when you – have completed five years of continuous service, – turn age 65, or – die.
When You Can Receive a Distribution	▪ The profit sharing plan is designed to help you save for your retirement. You are eligible to receive a distribution of your vested account balance – when you retire, – if you become totally disabled, or – when you leave the corporation. ▪ Your beneficiary is entitled to a distribution in the event of your death.
Your Beneficiary	▪ When you enroll, you name a beneficiary to receive your plan balance in the event of your death. ▪ If you are married, your spouse is automatically your beneficiary. ▪ To change your beneficiary, complete and submit a new form. Forms are available by visiting HR Solutions @ccess online through The McGraw-Hill Companies Intranet or by calling HR Solutions @ccess at 1-800-358-3603.

For more information, see Profit Sharing Plan. *For more information on investing, see* Investing Your Assets. *For more information on taxes, see* Taxes.

The Pension Plan at a Glance

Eligibility and Enrolling	▪ Generally, you are eligible to begin participating if: – you are at least 21 years old, and – you have at least one year of continuous service, and – you are an active employee working in the United States or an active U.S. employee temporarily working abroad. ▪ Once you meet eligibility requirements, you are automatically enrolled.
The Amount of Your Benefit	▪ Your pension plan benefit is based on your annual eligible pay. You accrue a benefit equal to 1% of your eligible pay for each year you participate in the plan.
When Your Benefits Are Vested	▪ You are vested when: – you complete five years of continuous service, or – you reach age 65, regardless of your years of service.
When You Can Retire and Receive Benefits	▪ Your normal retirement date is the last day of the month in which you reach age 65. ▪ You may retire early if you are age 55 and have completed at least 10 years of continuous service.
How Your Benefit Is Paid	▪ You choose how your retirement benefit is paid to you. Your options include the following: – Single Life Annuity – Joint and Survivor Annuity – Term Certain and Life Annuity
If You Leave Before Retirement	▪ If you are vested in the plan when your employment ends, you are eligible to receive your pension plan benefits when you reach your normal retirement age, age 65. ▪ If you become disabled and are receiving long-term disability benefits, you continue to earn pension plan benefits as long as you are receiving long-term disability benefits from the corporation's Long-Term Disability Plan. ▪ You do not earn pension plan benefits during your service with a nonparticipating subsidiary. ▪ Your spouse is eligible to receive pension plan benefits after your death if you are vested in the plan when you die.
If You Participated Before July 1, 1986	▪ You or your beneficiary will always receive a benefit that is at least equal to the contributions you made to the plan before July 1, 1986, plus interest. ▪ You may be eligible for a transition benefit.
When You're Ready to Retire	▪ When you're ready to retire: – notify the Human Resources Service Center (HRSC) 90 days before the date you plan to retire, – choose how you want your benefits to be paid to you, and – if you've elected a payment option other than the Single Life Annuity, name a joint annuitant or beneficiary to receive benefits if you die

For more information, see Pension Plan.

Other Benefits

The EAP at a Glance

Eligibility	▪ EAP benefits are available to all employees of the corporation and their family members.
Services Offered	▪ The EAP offers two primary services: – The EAP is a confidential assessment and referral service designed to help you and your immediate family members resolve personal issues that may affect your health, family life, or job performance. – The EAP also provides work/life, dependent care and elder care information. These resources can provide you with a list of childcare or elder care providers in your area, along with guidelines and information to help you evaluate these dependent care options and choose the one that is right for you.
Confidentiality	▪ Services provided through the EAP are strictly confidential. Information about you or your family members will not be released unless you give written permission or unless the law requires it.

For more information, see Employee Assistance Program.

Long-Term Care Insurance at a Glance

Long-Term Care Insurance	▪ The McGraw-Hill Companies Long-Term Care (LTC) Plan offers you access to insurance coverage to help you pay for long-term care expenses. – Insurance coverage is provided by the John Hancock Life Insurance Company. ▪ Under the LTC Plan, you choose a daily maximum benefit (DMB) to be paid to you. – Your DMB is the maximum benefit the plan will pay for your care each day you're qualified to receive benefits. – You can choose a DMB of $100, $200, or $300. – Depending on the DMB you select, there is also a corresponding lifetime maximum benefit—a limit on the total benefits the plan will pay to you over your lifetime.
Eligibility	▪ You are eligible for long-term care insurance if: – you are an active employee, – you are regularly scheduled to work at least 20 or more hours per week (whether full-time or part-time), and – you reside within the U.S. on your date of application and effective date of coverage. ▪ You are also eligible if you are a retiree. ▪ If you are eligible for coverage, you may also enroll certain family members or a domestic partner.
Enrolling	▪ To enroll, call John Hancock at 1-800-435-3538 to request an application form, or apply online at mcgraw-hill.jhancock.com (username: mcgraw-hill, password: mybenefit). – You must also complete the statement of health on the application form. – Fill out a separate form for each person aplying for coverage.

Paying for Coverage	▪ You pay the full cost of your coverage through payroll deductions (or through pension deductions if you are retired). – Although premiums are paid through payroll or pension deductions, they are paid on an after-tax basis. ▪ If your spouse or other eligible family member enrolls for coverage, he or she must pay John Hancock directly for coverage.
How Benefits Are Paid	▪ Before your benefits can begin: – you must be certified for benefits under the LTC plan, and – you must pay the full cost of your long-term care services for 90 days—this is called the Qualification Period. You must remain certified for benefits during your entire Qualification Period. ▪ Long-term care insurance benefits are generally paid on a monthly basis. ▪ Benefits can be paid to you or your service provider.

For more information, see Long-Term Care Insurance.

Auto, Home, and Renter's Insurance at a Glance

Eligibility	▪ You are eligible to apply for coverage if: – you are an active full-time or part-time employee, and – you are regularly scheduled to work at least 20 hours per week. ▪ All applicants must meet underwriting guidelines to qualify for coverage.
Enrolling	▪ You may apply for coverage as of the first day you are eligible. To apply, call the Group Auto and Home Insurance Program at 1-800-438-6381.
Your Options	▪ The program offers many different kinds of insurance, including auto, homeowner's, renter's, personal excess liability, and more. The coverage available through the METPAY program varies by state.
Filing a Claim	▪ To file a claim or make changes to your coverage, call METPAY at 1-800-438-6381.

For more information, see Auto, Homeowners, Renter's Insurance.

Tuition Refund Program at a Glance

Eligibility	▪ You are eligible to participate in the program if: – you are an active full-time or part-time employee, and – you are regularly scheduled to work at least 20 hours per week.
Eligible Courses	▪ Each course you are reimbursed for must meet all of the following eligibility requirements. – Each course must start after you begin your employment with The McGraw-Hill Companies. – The course must improve your current competence as an employee in your current job. – The course must be job related. – The course must be offered by an accredited college, university, or other institution and be given during a school term or on a semester basis. – All courses must earn college credit regardless of whether the course is applied toward a degree or certificate program.
Eligible and Ineligible Expenses	▪ The program will provide reimbursement for your unsubsidized tuition costs and applicable registration fees only. ▪ Expenses not eligible for reimbursement include books and equipment costs, service and/or processing fees, general fees, and college/university fees.
Receiving Your Reimbursement	▪ You must complete a Tuition Refund Application and send it to the HRSC for processing within 60 days of completing the course.

For more information, see Tuition Refund Program.

Severance Benefits at a Glance

Eligibility	▪ You are eligible to receive separation pay benefits if: – you are a regular employee employed in the United States in accordance with The McGraw-Hill Companies Human Resources Guide, and – your employment is terminated as a result of an involuntary termination, including a reduction in force, your job being relocated or eliminated, your job being outsourced, your temporary layoff being converted to a permanent layoff, or any other circumstances designated in writing by the plan administrator, and – you continue to perform your job duties until your termination date, unless the plan administrator decides otherwise.
Benefit Amounts	▪ In general, you will receive one week's base pay for each year of continuous service, up to a maximum of 26 weeks' base pay, prorated for each completed month of service. ▪ You are eligible for double your normal separation pay benefit, up to a maximum of 52 weeks' base pay, if you sign and return a termination agreement and general release within the time required by the corporation.
Notice of Termination	▪ When your employment is to be terminated for any reason that could qualify you for separation pay benefits, you generally will be given advance notice as follows: – 3 weeks, if you have fewer than 5 years of continuous service – 4 weeks, if you have at least 5 but fewer than 10 years of continuous service – 6 weeks, if you have 10 or more years of continuous service. ▪ Any notice you receive is inclusive of, and not in addition to, any notice required by law. ▪ If the plan administrator decides that advance notice is not practical, is not in the best interests of the corporation, or is unwarranted, in place of notice you will receive a lump-sum payment equal to one week of pay for every week of advance notice you would otherwise have received.
How Benefits Are Paid	▪ If you do not sign and return a termination agreement and general release, your benefit is paid in a lump sum on or shortly after your final date of employment. ▪ If you sign and return a termination agreement and general release, you have the option to receive your benefit: – as a lump sum on or near your final date of employment, or – in installments. ▪ If you elect installments, they will be paid to you semi-monthly, in accordance with the corporation's regularly scheduled payroll practice.
Other Benefits Coverage	▪ If you choose to receive your separation benefit: – As a lump sum, you may be eligible to continue some benefits coverage under COBRA. – In installments, you may be eligible to continue some benefits coverage while you are receiving your installments, in addition to any extension period allowed under COBRA. – In installments, you cannot receive a distribution of your 401(k) savings plan (SIP) or profit sharing plan (ERAP) account balances until after the end of your separation pay period.

For more information, see Severance Benefits

Other Benefits

Healthcare Benefits

The McGraw-Hill Companies offers a variety of healthcare benefits for employees, including:

- Medical coverage (including prescription drug and mental health/chemical dependency coverage)
- Dental coverage
- Vision coverage

In addition to this employee coverage, the corporation also offers healthcare coverage for retirees and expatriates. Individuals no longer eligible for coverage may be able to continue coverage at their own expense through the COBRA law.

This section explains the corporation's healthcare benefits and includes participation information such as eligibility and enrolling.

In This Section **See Page**

Terms to Know

Active Employee

For benefits eligibility purposes, you are considered an active employee if you are receiving a regular paycheck (directly from the corporation) to pay wages for services you are currently providing to the corporation.

Subrogation and Reimbursement

Subrogation is a legal right the plan can assert to recover the benefits it pays for accidental injuries or illnesses. The plan can recover these benefits from the parties who caused the accident or from their insurers and/or other insurers that provide coverage for the accidental injury or illness.

Reimbursement is a legal right the plan can assert to recover its benefit payments from you or your family members. There is a duty to reimburse the plan when a settlement or payment arising out of an accidental injury or illness has been made without providing for payment back to the plan.

Participating in Healthcare Coverage

The benefits described in this handbook are provided for employees of The McGraw-Hill Companies, Inc. This section explains which employees are eligible to participate in healthcare benefits and discusses some aspects of your employment that can affect your participation, such as your regularly scheduled work week and your continuous service. You can also find details about which of your family members are eligible to participate under the benefit plans offering dependent coverage and information about how to enroll these individuals.

Healthcare Participation Information Only

The information in this section applies to healthcare benefits only, including medical, dental, and vision coverage.

For eligibility and participation information regarding the corporation's other benefits, see the separate descriptions of each benefit in this handbook.

In This Section **See Page**

Employee Eligibility

Ineligible Individuals

Even if you meet the eligibility requirements, you cannot participate if you fall into one or more of the groups listed under "Individuals Not Eligible" in *Rules and Regulations*.

In general, you are eligible to enroll for and participate in most of the corporation's benefit plans if:

- you are employed by a corporation business unit that participates in the applicable plan,
- you are an active full-time or an active part-time employee,
- you are regularly scheduled to work at least 20 hours per week, and
- you are employed in the United States, or you are a U.S. employee temporarily working abroad.

If you meet these eligibility requirements when first hired by the corporation, you are eligible as of your hire date. If you do not meet these requirements when first hired, you are not eligible until your employment status changes to meet the eligibility requirements.

Different Eligibility for Different Plans

Eligibility rules differ for the different benefits for a variety of reasons. In some cases, such as for plans in the Retirement Program, federal requirements determine who is eligible. For other plans, insurance contracts approved by state insurance commissions control eligibility. See those other sections for their eligibility details.

Active Employees

The benefit plans described in this handbook are designed primarily for active employees and their eligible family members. Although you may be able to continue participating in some of the plans if your active employment ends (for example, if you go on an approved, unpaid leave of absence), to begin participating you must be considered to be an active employee.

For information on your eligibility to continue participating in healthcare coverage when you are not an active employee, see the separate descriptions of the plans and "What Happens to Healthcare Coverage When..."

Regular Work Schedule

Most of the corporation benefits require that you be regularly scheduled to work 20 or more hours a week to be eligible. For benefits eligibility purposes, your regularly scheduled work week is based on your regular work schedule, not the actual hours you work. If your regularly scheduled work week changes, your eligibility to participate in corporation benefits may change.

Fewer Than 20 Hours

If you are regularly scheduled to work fewer than 20 hours a week or if you are a temporary employee, you are not eligible for healthcare benefits through the corporation.

Work in the United States

To be eligible for most of the benefits described in this handbook, you must be working for the corporation in the United States of America (including its territories and commonwealths), or you must be a U.S. employee temporarily working abroad.

Family Eligibility

If you are an eligible employee, you may enroll certain family members for coverage under the corporation's healthcare plans.

One thing to keep in mind when enrolling eligible family members for healthcare coverage is that you must enroll them for the same coverage you choose for yourself. The benefit plans that offer coverage for family members generally enable you, as an eligible employee, to cover:

- One adult other than yourself, choosing from among:
  - your spouse (he or she must be your legal spouse according to the laws where you live),
  - your domestic partner, or
  - your or your spouse's:
    - parent,
    - grandparent,
    - sibling, or
    - adult child age 23 or older.
- Any eligible dependent children of:
  - yourself, or
  - your domestic partner.

Coverage for adult family members is subject to the eligibility provisions of the individual healthcare plans. A plan may have additional eligibility requirements for family members—for example, to be eligible for medical or dental coverage, a qualified adult relative must also be under age 65. There also may be other limits on coverage for qualifying adults, depending on the healthcare plan you choose. If you have any questions about such coverage, you should see the plan summaries at *www.benefitsplanner.com* or the *Healthcare Option Summaries*, or you can contact the Human Resources Service Center (HRSC) at benefits_hrsc@mcgraw-hill.com or at 1-888-THE-HRSC (1-888-843-4772).

See "Qualifying Adults Other Than Your Spouse," "Dependent Children," as well as "Court Orders" in the *Rules and Regulations* section for more information.

State Coverage Limits

Some of the benefit plans available through the corporation are provided under insurance contracts that must be approved by and filed with state insurance commissions. In some locations, these contracts do not include coverage for certain employees who may be eligible for other corporation benefits.

For example, although many of the healthcare plans available through the corporation allow you to cover domestic partners, domestic partner coverage is not available in all locations or for all coverage options.

Qualifying Adults Other Than Your Spouse

If you are an eligible employee, you can enroll one of the adults listed under "Family Eligibility," subject to the following requirements.

Every employee can cover one other eligible adult.

Domestic Partners

Domestic Partner Affidavit

You must complete a corporation-provided affidavit confirming your relationship in order to cover a domestic partner. You can obtain an affidavit from the HRSC.

If you are in a relationship that qualifies as a domestic partnership—whether with a member of the same sex or the opposite sex—you may enroll your domestic partner in the plans that allow for domestic partner coverage. (Not all plans provide domestic partner coverage.)

For your relationship to qualify as a domestic partnership, you must complete an affidavit provided by the corporation. On the form, you must state that you and your partner meet the following requirements:

- You share a committed and mutually dependent relationship, evidenced by a shared residence and record of financial interdependence.
- You are both of legal age, that is, not considered minors under applicable state law.
- Neither of you is married nor has another domestic partner.
- You are not so closely related that legal marriage would be prohibited.

In addition to providing the affidavit, you may also be required to provide documentation proving the nature of your relationship. Examples of documentation that would satisfy this requirement include joint checking or savings accounts, a mortgage under both your names, or a domestic partner registration certificate from a local authority where these relationships can be certified.

There may be important cost and tax implications if you cover your domestic partner. Information on these issues is included in each of the applicable plan descriptions.

Eligible Dependents of a Domestic Partner

In order to cover your domestic partner's eligible dependents under the corporation plans, you must enroll your domestic partner for corporation coverage. If you do not enroll your domestic partner, you cannot cover your domestic partner's eligible dependents, unless your partner's dependents are eligible for coverage as your own dependents.

Adult Relatives

You may cover an adult relative for healthcare benefits if he or she is:

- under age 65,
- your or your spouse's dependent as defined by the Internal Revenue Code, and
- not eligible for healthcare coverage from another source, including Medicare or other government-sponsored programs.

Covering Non-Spouse Adults

To cover any adult relative other than your spouse or your domestic partner, you must complete an affidavit provided by the corporation attesting to the family member's eligibility. In addition, you may be required to provide evidence that the individual meets the Internal Revenue Code definition of dependent. For copies of the necessary enrollment and affidavit materials, call the HRSC.

To cover your or your spouse's parent or grandparent, the parent or grandparent must be a parent or grandparent by birth or legal adoption. Stepparents and stepgrandparents are eligible for coverage, provided they meet all of the other applicable eligibility requirements, including being your or your spouse's dependent as defined by the Internal Revenue Code.

To cover your or your spouse's sibling, the sibling must be a sibling by birth or legal adoption. Stepbrothers and stepsisters are eligible for coverage, provided they meet all of the other applicable eligibility requirements, including being your or your spouse's dependent as defined by the Internal Revenue Code.

To cover your or your spouse's adult child age 23 or older, the child must be a child by birth or adoption, a stepchild, or a child for whom you are legally responsible.

Eligible Dependents of a Qualified Adult Family Member

[redacted]

Dependent Children

If you are an eligible employee, you can enroll your eligible dependent children. Eligible children include children:

- by birth,
- by adoption (effective as of the date the child is placed for adoption),
- stepchildren, and
- children for whom you (or your domestic partner) are legally responsible.

If you are an eligible employee and have enrolled a domestic partner for corporation benefits, you can enroll that domestic partner's eligible dependent children for coverage.

Eligible dependent children include your (or your enrolled domestic partner's) children (as defined above) who:

- are under age 23,
- are not married,
- are not employed on a full-time basis,
- are dependent on you for financial support, and
- either:
  - live with you, or
  - are away at school.

Disabled Dependent Children

If your (or your domestic partner's) child becomes totally and permanently disabled before age 23, that child is eligible for coverage as your dependent as long as:

- the child is not married,
- the child is living with you,
- the child remains disabled, and
- the child is dependent on you for financial support.

To cover disabled dependent children, you must verify in writing that the disability occurred before age 23. You have 31 days from the child's 23rd birthday to provide this verification.

Enrolling and Changing Coverage

For the corporation's healthcare benefits, you must formally enroll to participate. If you are eligible, you can enroll yourself and any eligible dependents in medical, dental, and vision coverage. For each benefit you enroll in you must select a coverage level:

- Employee only
- Employee plus one eligible family member
- Employee plus two or more eligible family members

Because of the tax advantages available to you through the corporation's healthcare coverage, Internal Revenue Service (IRS) rules determine when you can change your participation.

To enroll your family members for any corporation healthcare coverage:

- you must meet the employee eligibility requirements for the plan,
- the family members you want to cover must meet the eligibility requirements for the plan, and
- the benefit plan must provide coverage for the eligible family member you wish to cover.

When First Eligible

You can enroll to participate in the corporation's healthcare coverage during the 31 days after you become eligible. In most cases, if you do not meet this 31-day deadline, you cannot enroll for coverage until the next annual enrollment period, unless:

- you have a qualifying change in status, as explained in "After Qualifying Events," or
- you waive healthcare coverage from the corporation because you have other employer-provided coverage and you lose that other coverage.

During Annual Enrollment

Each year, the corporation holds an annual enrollment period. During this period, you have the opportunity to change your participation in the corporation's benefits for the coming calendar year.

After Qualifying Events

The enrollment choices you make when you first become eligible or during annual enrollment are in effect for the entire calendar year for which you enroll.

However, because your needs for benefits typically change when you experience certain family events—such as getting married or having a baby—you are allowed to make changes in some situations, in accordance with federal rules, as long as you make your change within 31 days after the event.

Changes in Status

Various events may qualify you to make certain changes to your healthcare coverage. Generally, the events must affect your or your eligible family member's eligibility for coverage under an employer plan (including plans of other employers). Examples of qualifying events include:

- a change in your legal marital status, such as your marriage, divorce, or legal separation,
- a change in the number of your eligible dependents, including:
  - the birth or adoption of a child, or
  - the death of your spouse or other benefits-eligible family member.
- a change in your or one of your eligible dependent's employment status (such as starting a new job, terminating employment, going on leave, etc.),
- a change in one of your eligible dependent's eligibility for coverage (such as when your dependent child reaches the eligibility age limit, or when your position changes in a way that affects your eligibility),
- your eligible dependent's loss of insurance coverage from another source,
- a change in your or one of your eligible family member's entitlement to Medicare coverage, or
- a change in your or one of your eligible family member's residence, as it changes the healthcare options from which that person can choose.

You may also be able to change your benefit elections due to certain other events, such as the following:

- If there is a significant change in the cost of coverage, plan design, or benefit options under your spouse's or dependent's employer's plan, you may be able to make a corresponding election change under the corporation's plan (for example, you may drop coverage under your spouse's plan and elect coverage under the corporation's plan if the cost of coverage under your spouse's employer's plan significantly increases).
- If there is a "significant curtailment" of your coverage, you may be able to change your election and elect another option with similar coverage.
  - "Significant curtailment" may mean, for example, the elimination of hospital/physician networks or specialty vendors. "Significant curtailment" may also be based on plan design changes.
- You may be able to drop coverage under the corporation's plan for yourself or your spouse or dependents to elect similar coverage under your spouse's employer's plan.
- If you, your spouse or dependent becomes entitled to, or loses entitlement to coverage under a government institution, Medicare, Medicaid, or a state children's health program, you may make corresponding changes to your benefit elections under the corporation's medical plan.

Network Provider Changes Are Not Qualifying Events

The enrollment choices you make are in effect for the entire calendar year in which you enroll. In most cases, changes in your plan's network coverage are not qualifying events unless they are considered significant curtailments. For example, if your primary care physician (PCP) is no longer available through the network, you cannot change your coverage until the next annual enrollment period.

How to Make Changes

You have 31 days from the date of a qualifying change in status to enroll in or change your participation. (Remember that the only coverages you can change because of changes in status are healthcare coverages, plus your participation in FSAs.) Provided you meet this 31-day deadline, the new coverage you choose begins as of the date of the event—for instance, as of the date of your marriage. To make a change, you must access Employee Self-Service.

Keep in mind that any changes you make to your coverage must be consistent with the change in your status. For instance:

- If you lose one of your eligible dependents (through death or divorce, or the dependent reaches age 23), you can cancel coverage for that dependent, but not for any other individual.
- If you want to drop coverage for an enrolled member of your family because that person has become eligible for other coverage, you may only drop the coverage from The McGraw-Hill Companies if the person actually enrolls for the other coverage.
- If you get married and want to cover your new spouse, you may change your medical coverage level from the "employee only" coverage level to the "employee plus one" coverage level, but you cannot change from one medical option to another.

After Losing Other Coverage

Some eligible employees may choose not to enroll for corporation healthcare coverage because they have coverage available from another source, such as from a spouse's employer's plan.

If you do not enroll for The McGraw-Hill Companies' healthcare benefits because you have other health insurance coverage and that other coverage ends, you may enroll for corporation healthcare coverage at any time during the 31 days after the other coverage ended. If you do not enroll within 31 days, you may not enroll until the next annual enrollment period.

If you enroll as described above, your participation in The McGraw-Hill Companies' benefits becomes effective as of the date your other coverage ended.

Paying for Coverage

The corporation pays most of the cost of your healthcare coverage. Your share of the total cost generally depends on:

- your salary (for medical coverage only),
- the coverage option you choose, and
- the level of coverage you select (employee only, employee plus one eligible family member, or employee plus two or more eligible family members).

In most cases, you pay your contributions for medical, dental, and vision coverage through payroll deductions using pre-tax dollars.

Contribution rates may be adjusted annually to accommodate changes in the cost of coverage. At each annual enrollment period, you will be notified of the coming year's contribution rates.

Non-Spouse Adults

Some of the healthcare options offer coverage for qualified adult family members, including domestic partners. If you enroll a domestic partner or another eligible adult family member, you may be required to pay for this coverage with after-tax dollars. For more information about enrolling domestic partners or other adult family members, see "Family Eligibility."

Contributions When Not on Payroll

If you are eligible to continue participating in a corporation plan when you are not an active employee, you must make arrangements to pay any required contributions to the corporation directly. Before you go on inactive status, call the HRSC to discuss your options and make appropriate arrangements.

Depending on the reason why you are not active, your payment options may include:

- prepaying contributions, through a before- or after-tax deduction from your final paycheck(s) before you become inactive,
- prepaying contributions on an after-tax basis with a direct payment to the corporation, or
- paying your contributions on an installment basis, after taxes, according to a schedule that would be worked out by the HRSC before you become inactive.

When Coverage Begins

The date when your coverage begins depends on when you make your healthcare choices:

- As a new employee who meets the eligibility requirements, coverage begins the first day you are actively at work, provided you enroll within 31 days of the date you are hired.
- As a newly eligible employee, coverage begins as of the day you meet the eligibility requirements, provided you enroll within 31 days of becoming eligible.
- If you enroll for coverage during the annual enrollment period, the coverage you choose during enrollment begins the following January 1.
- If you enroll for coverage within 31 days of a qualifying change in status (such as getting married, as explained under "After Qualifying Events"), coverage begins as of the date of the change in status.

When Coverage Begins for Your Family Members

If you enroll your eligible family members at the same time that you enroll, their coverage begins when your coverage begins. If you enroll your eligible family members at a later time, the date when their coverage begins depends on when you enroll them:

- If you enroll an eligible family member for coverage during the annual enrollment period, coverage begins the following January 1.
- If you enroll an eligible family member for coverage within 31 days of a qualifying change in status (such as getting married, as explained under "After Qualifying Events"), coverage begins as of the date of the change in status.

ID Cards

When you enroll for medical or dental coverage, you receive a card that identifies you as a plan participant. Carry your card with you, as doctors and hospitals will ask to see it when you receive care. If you need care before you receive your card or if you lose your card, call your plan for information about your coverage before you receive treatment, so you can be sure the plan you have enrolled in covers the treatment you are about to receive.

When Coverage Ends

Your medical, dental, and vision coverage as an employee ends on the earliest of the following dates:

- The last day of the month in which you retire or otherwise end your employment (whether voluntarily or involuntarily). If you are eligible for severance benefits under the Separation Pay Plan and you choose to receive those benefits in installments, some benefits can continue while you are receiving those installments. See "Continuing Benefits Coverage" in the section on the Separation Pay Plan in *Other Benefits*.

- The last day of the month in which you no longer meet the eligibility requirements for coverage
- The last day of the month in which you stop making the necessary contributions toward the cost of coverage
- The day the corporation discontinues the plan
- The day you die

When Coverage Ends for Your Family Members

Your covered family members' medical, dental, and vision coverage ends on the earliest of the following dates:

- The day your coverage ends (as described in "When Coverage Ends"), with one exception—in case of your death, their coverage will end six months following the last day of the month in which you die
- The last day of the month in which your family member no longer meets the eligibility requirements for coverage
- The last day of the month in which you stop making the necessary contributions toward the cost of your family members' coverage
- The day the corporation discontinues coverage for family members under the plan

COBRA

If your medical, dental, or vision coverage ends, you can continue coverage under a federal law known as COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985. (Your enrolled family members may also continue their coverage.) If you continue coverage under COBRA, it is at your expense and for a specified period of time. For details, see *COBRA Health Coverage*.

If You Have Other Coverage

If you or an eligible family member has coverage under the corporation's medical or dental benefits programs and coverage under another healthcare plan, the corporation's benefits are coordinated with those provided by the other plan.

If the corporation plan involved is a traditional medical or dental indemnity plan or the UnitedHealthcare Point-of-Service (POS) Plan, the following coordination of benefits rules will apply. For all of the other plans, the coordination of benefits rules will be specified by the plan insurer.

The corporation's coordination rules are designed to determine how much each plan pays when you or your family members are covered under more than one healthcare plan. The rules involve two steps:

- Determining which plan pays first (the plan that pays first is your "primary coverage")
- Determining how much the corporation plan will pay

Which Plan Pays First

If you or a family member has coverage under more than one plan, first submit your expenses to the primary plan, then submit them to the secondary plan. How do you know which plan is primary? Here are the rules:

- **For you**—The corporation's coverage is primary. Submit your healthcare expenses to the corporation's plan first, then to the other plan.
- **For your spouse or other covered adult**—Your spouse's employer-sponsored plan is primary, if he or she is enrolled in it. Submit your spouse's healthcare bills to his or her plan first, then to the corporation's plan.
- **For your children**—When a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in the calendar year pays benefits first. If you and your spouse have the same birthday, the plan that has been covering your child longer pays benefits first. If the other plan has not adopted this "birthday rule," that plan's order of determination rules determine which plan is primary.

If you are divorced, legally separated, or remarried, the plans pay benefits in this order:

- The plan of the parent with custody
- The plan of the spouse of the parent with custody
- The plan of the parent without custody
- The plan of the spouse of the parent without custody

Sometimes a court assigns responsibility to one parent for paying a child's healthcare expenses, for example, if there is a divorce. Court decrees take precedence over all other rules, as long as the provider of the plan covering that parent has knowledge of the court decree before benefits are paid in the plan year. If the plan provider is not informed of the assignment, the terms of the decree are not applicable until the next plan year.

- **If you are covered under Medicare**—If you are still working for the corporation and you have Medicare coverage, the medical coverage you have through the corporation is primary, so submit your medical bills to the corporation's plan first. Then submit any medical expenses not covered by the corporation's plan to Medicare for payment.
- **If you are receiving benefits from Workers' Compensation**—If you are receiving benefits from Workers' Compensation, contact the HRSC. The HRSC will call the Corporate Risk Insurance Department in New York, which will coordinate payment of all Workers' Compensation claims with the insurance company.
- **If none of these rules applies**—If none of these rules applies, the plan that has covered the person for the longer period of time pays benefits first.

How Much the Plan Pays

If the corporation plan is primary...

- Then the corporation plan's benefits are paid according to the regular plan provisions, and the other plan pays benefits according to its own coordination of benefits provisions.

If the corporation plan is not primary...

- Then the primary plan pays benefits first. After the primary plan pays benefits, the corporation plan determines the benefits that would be payable if the corporation plan were primary (that is, as if there were no other coverage). All of the corporation plan's rules will apply in determining the benefit that is payable—including the corporation plan's deductible and maximum benefit provisions and any applicable reasonable and customary limits determining what portion of the total cost is covered. Once the amount payable if the corporation plan were primary is determined, the corporation plan will pay the lesser of:
  - the amount the corporation plan would pay if it were primary, or
  - the amount of the charge covered under the corporation plan remaining after the primary plan has paid benefits. (For example, if the charge covered under the corporation plan is $100 and the primary plan paid $70, the amount remaining would be $30.)

Coordination of Benefits

Suppose Susan has elected the "employee plus one" level of coverage in The McGraw-Hill Companies Medical Plan. Her husband, Tim, is enrolled in his employer's plan, which also pays 80% of covered charges. For purposes of this example, assume the charges being discussed are covered by both plans, that the charge is within the reasonable and customary limits of both plans, and that Susan and Tim have already met their deductibles under both plans.

Tim has a medical bill for $1,000 and his plan is primary. The McGraw-Hill Companies Medical Plan is secondary. Here is what the plans would pay:

First, submit Tim's covered charges to his plan.	$1,000
Tim's plan pays 80%.	$800
The amount of the charge covered under the corporation plan remaining after the primary plan (Tim's plan) has paid benefits is...	$200
The amount of the charge covered under the corporation plan if there were no other coverage is...	$800
The McGraw-Hill Companies Medical Plan pays the lesser of $800 or $200, paying...	$200

Subrogation and Reimbursement

The corporation's benefits include several plans that provide benefits in case of accidental injury or illness—such as coverage for medical treatment of your illness or injury. Under these corporation plans, if you receive benefits from other sources because of the accidental injury or illness, the corporation's plans are entitled to repayment of the benefits provided because of the accident.

For example, Mario is in an auto accident and receives medical treatment for his injuries. Mario participates in one of the corporation's medical plans, so his treatment is covered by that plan, and he receives benefits from the plan. If Mario later receives a settlement from the driver of the other car involved in the accident, the corporation medical plan is entitled to be repaid for the benefits it provided.

The plan may be entitled to some or all of the amounts you receive because of the accident, under two legal rights—subrogation and reimbursement.

If you are involved in an accident and receive any benefits from the corporation plans, be sure to ask the HRSC if you need to be aware of any subrogation or reimbursement issues. You may be required to provide information about your accident to help the plan determine who could be held liable for the accident. In addition, you are required to cooperate with the plan and must not take action that is harmful to the plan's right to subrogation.

Under subrogation and reimbursement rights, a plan can postpone payment of claims in cases where third-party recovery is a possibility.

What Happens to Healthcare Coverage When...

In certain instances, you may be entitled to continue your healthcare coverage, even if your employment with the corporation ends.

You Become Disabled

If you are disabled, your employee medical, dental, and vision coverage can continue up to age 65, as long as you are receiving benefit payments from one of the corporation's disability plans and you continue to make the required contributions for coverage.

Medical Coverage After 30 Months of Disability

You may be eligible for Medicare after 30 months of disability (counted from the day you become disabled), so your coverage may vary as described below.

If you qualify for Medicare, your employee medical coverage stops and you can choose from the following two options:

- You can enroll for The McGraw-Hill Companies Drug Supplement Plan, or
- You can waive corporation medical coverage.

If you do not qualify for Medicare, you can continue your employee medical coverage as long as you remain disabled, until you become eligible for Medicare. If you continue your coverage this way, your cost for coverage will be the same as the Medicare Part B coverage for your corporation coverage. At age 65, you may be eligible for retiree medical coverage.

Coverage for Your Family Members

Medical, dental, and vision coverage for the family members who were covered at the time your disability began will continue for up to 30 months, provided you continue to make the required contributions for coverage.

After 30 months, your covered family members can continue their coverage in one of the following ways:

- If you are eligible to retire, your family members may be eligible to receive retiree healthcare coverage as your dependents. See *Retiree Healthcare Coverage* for details.
- If you are not yet eligible to retire, your family members can continue their coverage under a federal law known as COBRA. For details, see *COBRA Health Coverage*.

Paying for Coverage When You Are Disabled

The non-COBRA contributions for you or your covered family members will be the same as those charged for active employees, unless you are paying Medicare part B rates, as explained above.

If you are receiving benefits from the Short-Term Disability (STD) Plan...

- your coverage will continue during your absence, with the contributions deducted from your STD benefits on a pre-tax basis, as they are from your regular paychecks.

If you are still disabled when your eligibility for STD benefits ends and you begin receiving long-term disability (LTD) benefits...

- you may continue your coverage (although your medical benefits might change) while you are disabled up to age 65, but you will have to make arrangements to pay the contributions for that coverage on an after-tax basis. For information on paying contributions when you are receiving Long-Term Disability (LTD) Plan benefits, see "Contributions When Not on Payroll."

You Take a Leave

Medical, dental, and vision coverage continues for you and your eligible family members for the entire period of your leave, provided you continue to make the required contributions. The contributions for you and your covered family members will be the same as those charged for active employees. However, you will have to pay contributions for coverage on an after-tax basis, unless your leave of absence is because you are disabled and you are receiving STD benefits, as described in "You Become Disabled."

For information on paying contributions when you are on an unpaid leave of absence, see "Contributions When Not on Payroll."

You Retire

You and your family members may receive medical, prescription drug, dental, and/or vision coverage if, at the time you retire, you meet certain eligibility requirements. See *Retiree Healthcare Coverage* for more information.

If you are not eligible for retiree coverage, you may continue coverage under the plan for yourself and your covered family members through a federal law known as COBRA. For information on how long COBRA coverage can last, see *COBRA Health Coverage*.

Your Employment Ends

If you are enrolled in healthcare coverage at the time you leave, you may continue coverage under that plan for yourself and your covered family members through a federal law known as COBRA. See *COBRA Health Coverage* for details.

You Die

If you die while an active employee, your covered family members may continue healthcare coverage for six months, provided they continue to make the required contributions. (During this six-month period their contributions will be the same as those for active employees.) After six months, your covered family members can continue coverage under a federal law known as COBRA. This six-month period counts against the overall time allotment for COBRA coverage. For details, see *COBRA Health Coverage*.

If you die while an active employee and you were eligible to participate in the retiree medical plan, your surviving spouse can enroll in the retiree plan. However, your spouse cannot decline or waive coverage at the time of your death and enroll at a later time, for example, during the annual enrollment period.

Medical Coverage

The corporation provides a package of competitive medical benefits to help with your healthcare needs and protect you from the potentially high costs of medical care. These benefits are provided through the corporation's Comprehensive Medical Expense Insurance Plan.

Employees are located throughout the country, so the corporation contracts with carrier networks—primarily the UnitedHealthcare Point-of-Service (POS) Plan and various Health Maintenance Organizations (HMOs)—to provide medical coverage. As a result, your medical coverage options vary depending on where you live. In areas where Point-of-Service coverage is not offered, you may be eligible for coverage under a traditional medical indemnity plan.

In This Section **See Page**

Your Medical Options

Your EAP Benefits

The corporation makes the Employee Assistance Program (EAP) available to all active employees, even if you do not elect medical coverage. The EAP provides confidential counseling services for a broad range of issues. See *Employee Assistance Program* in the *Other Benefits* section for more information, or call 1-800-544-8320.

Each of the medical options available through the corporation provides you with coverage for a broad range of expenses, including hospitalization, surgery, doctor's visits, and prescription drugs. Your alternatives for medical coverage vary depending on where you live. Contact the HRSC to find out which medical options are available in your area. For a summary of each of those options, see the plan summaries at *www.benefitsplanner.com*. You can also see the *Healthcare Option Summaries*.

In This Section — **See Page**

Managed Care Plan Availability

Even though a certain managed care plan—a POS plan or an HMO—may have a network where you live, the corporation may not offer it. The corporation tries to offer managed care plans in all areas. There can be several reasons why that may not be possible in your area. In some cases, insurance companies and medical plans require a minimum number of participants before they can set up a plan with a company. In some areas where there are established HMOs and POS plans, the corporation does not meet the minimum participation level required to offer these options. In other cases, the plan does not meet accreditation standards that the corporation uses to help ensure that you receive high-quality healthcare.

Point-of-Service (POS) Coverage

POS plans have networks of participating doctors, hospitals, and other healthcare providers. If you join the POS plan, when you or a covered family member needs medical care, you choose whether to:

- use a network physician or
- use a medical provider outside the network.

When you use network providers and follow the plan's rules for receiving in-network care, benefits are higher and your out-of-pocket expenses are lower than when you obtain out-of-network care. See *Point-of-Service (POS) Plan* for more information.

Health Maintenance Organization (HMO) Coverage

HMOs provide healthcare services to participants through a network of medical care facilities and doctors. Generally, when you join an HMO, you must use the providers and facilities affiliated with that HMO in order to receive benefits. See *Health Maintenance Organizations (HMOs)* for more information.

POS Plans vs. HMOs

Both POS plans and HMOs use networks of doctors and hospitals. Using in-network providers helps ensure that your care is coordinated and that it is effective and appropriate. The primary differences between the two plans is how coverage varies based on the provider you choose.

- With a POS plan, you have the flexibility to see a participating provider or to use a provider who is not part of the plan's network of doctors and hospitals. Your out-of-pocket cost for in-network coverage is generally lower than if you go out-of-network.
- In an HMO, you receive benefits only when you see that HMO's providers. If you use a doctor or hospital that is not affiliated with the HMO, you are responsible for the full cost of your care. (Out-of-area emergency care is usually an exception to this rule.)

Traditional Indemnity Plan Coverage

This option is available to employees only in areas where the corporation does not offer POS plan coverage. Indemnity coverage is provided through The McGraw-Hill Companies Medical Plan. The traditional indemnity plan pays a portion of your covered medical expenses after you satisfy a deductible each year. See *Traditional Indemnity Plan* for more information.

Waiving Coverage

You have the option to waive medical coverage from the corporation. If you waive coverage because you have other employer-provided healthcare coverage (such as through your spouse's employer's plan) and you later lose that coverage, you may be eligible to enroll in one of the corporation's options. See "After Losing Other Coverage" in *Participating in Healthcare Coverage* for more information.

If You Have Other Coverage

Part of the medical coverage options available through this corporation is a coordination of benefits feature. This coordination of benefits rules prevent duplication of payments when you or your family members are covered by another group medical plan, including government coverage such as Medicare or medical coverage under the no-fault or payment provisions of an automobile insurance contract. For more information, see "If You Have Other Coverage" in *Participating in Healthcare Coverage*.

How Coverage Works

The benefits that medical plans provide are typically determined using one of two models:

- copayments
- coinsurance

A plan may use both models. For example a plan may use a copayment model for preventive care office visits and a coinsurance model for hospitalization benefits.

Typically, HMOs use a model that is almost exclusively based on the copayment model. A POS plan will often use a copayment model for most in-network benefits and a coinsurance model for out-of-network benefits and certain in-network benefits (such as hospitalization). A traditional indemnity plan may use a coinsurance model except for select benefits that it covers through a network, such as prescription drug benefits.

The Copayment Model

A copayment is a predetermined fee (fixed dollar amount) that you may pay for certain services or care (including prescriptions). Copayments are used only when the service or care is being provided through a plan's provider network (including networks of pharmacies). If your plan uses a network of care providers and you use a provider who is not part of the plan's network, your benefits will not be based on copayments (and for some plans, such as HMOs, no benefits may be provided).

When a benefit is provided using a copayment, the only cost you typically pay is the copayment. However, in some cases a plan may combine the copayment and coinsurance models, so that you pay a copayment as well as a portion of the remaining cost as coinsurance.

Note that copayment benefits may be affected by frequency limits. For example, a plan may provide coverage at a certain copayment for up to 20 visits to a caregiver for a given condition within a given period. For more than 20 visits, the plan may not provide any more benefits or may provide them using a different copayment or a coinsurance model.

The Coinsurance Model

Coinsurance refers to an arrangement where you and the plan both pay portions of the covered cost of your care. The portions are expressed as percentages of the covered cost, and the plan typically pays the larger percentage. The percentage that you pay is called your coinsurance.

For example, in many cases, when you receive out-of-network benefits, POS plans pay 70% of the covered expenses. In those cases, your coinsurance is 30%.

Note that if the cost exceeds the amount that the plan considers reasonable and customary (R&C) for a given service or procedure, the plan will base its coinsurance determination on the R&C amount. So if your care provider charges more than the R&C amount, you pay 100% of the additional cost.

In addition to the R&C limits mentioned above and described in more detail under "Reasonable and Customary Limits," coinsurance benefits may also be affected by factors such as the following:

- If your plan uses a network of providers, whether your care is provided by a participant in that network or by an out-of-network provider
- Whether your care was authorized by the plan in advance, if advance authorization (sometimes called "precertification") was required by your plan for that kind of care (advance authorization does not apply for in-network benefits, if your plan uses a network)
- Annual deductibles (individual and family)
- Out-of-pocket maximums (typically per individual)
- Frequency limits (for a period or a condition)
- Maximum benefit limits (annual and/or lifetime).

Limits such as these are described in the plan summaries at *www.benefitsplanner.com*.

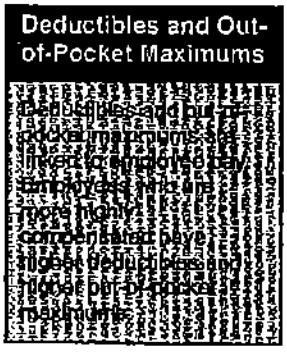
Reasonable and Customary Costs

Reasonable and customary (R&C) charges (sometimes referred to as usual and prevailing charges) are based on the normal range of fees charged by providers of similar standing (for example, with similar training and experience) in the same locality for treatment, services, or supplies for a similar condition, illness or injury. The plan updates the R&C amounts regularly.

With plans that use networks, reasonable and customary (R&C) limits generally do not apply for in-network care, because the network providers' charges are based on pre-negotiated schedules that are within the R&C limits. If you use an out-of-network provider or if you are in a plan that does not use a network of providers, the plan pays benefits only on the R&C amount.

If R&C limits apply and if your care provider charges more than the R&C amount, you are responsible for paying any difference. Charges that exceed the R&C amount do not count toward deductibles or out-of-pocket maximums.

Deductibles



For some benefits, the percentages used for coinsurance benefits apply only after you pay a certain amount of your expenses. This amount you must pay first, before the plan pays benefits, is called your deductible.

For the in-network benefits that use a coinsurance model, the coinsurance benefit percentage is paid immediately—there is no deductible that must be met before the plan pays benefits for in-network care.

The annual deductible is the amount you and each covered family member must pay each calendar year for covered expenses before the plan begins to pay benefits. After you satisfy the annual deductible requirement, the plan reimburses a percentage of covered expenses, using a coinsurance model.

An individual deductible may apply separately to you and to each of your covered family members, up to a family maximum.

A new deductible applies each calendar year.

For some plans, the deductibles are based on your annual salary.

For details on the deductibles required under your plan, see the plan summaries at *www.benefitsplanner.com*.

Family Deductible

To help limit the number of individual deductibles a family must meet each year, a plan may have a family deductible. A family deductible is the total amount you and your covered family members have to pay in deductibles for the plan each year, regardless of the size of your family. When your family satisfies the annual family deductible, the plan begins to pay its share for your entire family's covered medical expenses for the remainder of the calendar year.

Here's how the plan determines whether your family has satisfied the family deductible.

- The amount of each family member's individual expenses (up to the individual deductible amount) counts toward the family deductible.
- No more than the individual deductible amount per person can be counted toward the family deductible.

How the Family Deductible Works
Assume that Carol Miller is the employee enrolled in a healthcare plan, and that based on her annual salary her individual deductible in the plan is $400 and her family deductible is $800. Now suppose the Miller family has three members with $1,000 worth of covered expenses: Carol has $500, her husband, Keith, has $300, and their daughter, Lori, has $200. Here is how their expenses would be applied toward meeting the family deductible:

The family deductible	$800
Apply Carol's expenses (up to her individual deductible)	- $400
$400 of the family deductible remains	$400
Apply Keith's expenses	- $300
$100 of the family deductible remains	$100
Apply Lori's expenses to the deductible	- $100
The family deductible has been met	$ 0

Notice that the family deductible has been satisfied, even though only Carol has satisfied the individual deductible.

Out-of-Pocket Maximums

The out-of-pocket maximum limits the amount you and your family pay for covered expenses each year. Essentially, the out-of-pocket maximum protects you against having to pay extraordinary bills in a given year. Once your share of covered expenses reaches the out-of-pocket maximum, the plan pays 100% of the eligible charges for any additional covered expenses for the rest of the calendar year.

Some costs that you pay do not count toward your out-of-pocket maximum. Generally, the out-of-pocket maximum does not include:

- copayments (including prescription drug copayments),
- deductibles,
- mental health/chemical dependency expenses,
- expenses for care that requires advance authorization and which has not been approved in advance (including the expenses you pay as penalties for failing to get advance authorization),
- expenses over the reasonable and customary charge, or
- expenses not otherwise covered by the plan.

Some plans may have separate out-of-pocket maximums for certain benefits. For example, the UnitedHealthcare POS Plan uses separate out-of-pocket maximums for in-network care and out-of-network care. Expenses that count toward meeting the in-network out-of-pocket maximum do not count toward meeting the out-of-network out-of-pocket maximum, and vice versa.

Maximum Benefits

Many plans have limits on the amount of benefits the plan will pay per person per lifetime for certain benefits (such as out-of-network benefits in a POS plan). In addition, there may be lifetime, and in some cases annual, limits on the number of outpatient visits and inpatient days that will be covered for mental health and chemical dependency. Check the plan summaries at *www.benefitsplanner.com* for details.

What's Covered

See *Point-of-Service (POS) Plan, Health Maintenance Organizations*, or *Traditional Indemnity Plan* for information on what's covered under each type of plan. To learn what's covered under a specific medical plan, see the plan summaries at *www.benefitsplanner.com*. You can also contact your plan for information regarding what they cover.

In general, medical plans only cover health services and supplies that are deemed medically necessary or appropriate. That is, the plans cover care provided for the purpose of preventing, diagnosing, or treating a sickness, injury, mental illness, substance abuse, or general symptoms.

Examples of services covered by most of the corporation's medical plans include the following:

- Outpatient care, such as:
  - Office visits
  - Specialist visits
  - Preventive care, such as physicals, well-child care, and screening tests
  - Diagnostic testing, including lab tests and X-rays
  - Outpatient surgery
  - Emergency care
  - Prescription drugs
  - Outpatient mental health/chemical dependency care
  - Physical/occupational therapy
  - Home healthcare
  - Chiropractic care
  - Durable medical equipment
- Inpatient care, such as:
  - Inpatient surgery
  - Room and board for semi-private hospital accommodations
  - Intensive care
  - Inpatient mental health/chemical dependency care
  - Inpatient hospice care

Check Your Plan for Specific Information

Your medical plan may not cover all the services listed here. See the plan section in this handbook, your plan's summary at *www.benefitsplanner.com*, or contact your plan for specific information on what the plan covers.

Mastectomy Care and Reconstructive Surgery

By federal law, medical plans that cover mastectomies must cover certain reconstructive surgery following a mastectomy. Both in- and out-of-network benefits cover expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses, and the costs for treatment of physical complications at any stage of the mastectomy, including lymphedemas.

What's Not Covered

Some medical services and supplies are not covered under the POS plan, the corporation's traditional indemnity plan, or HMOs. The POS plan and some HMOs have additional exclusions, which are listed on the plan summary for that particular plan.

If you have a question about whether a service or supply is covered, call the plan to check. The claim administrator makes the final determination as to which charges are excluded based on the service agreements or insurance company policies that govern the corporation's plans. For some plans or options within a plan (such as the UnitedHealthcare POS Plan), the carrier is the claim administrator, who has final responsibility and authority for responding to claims and appeals. If you have any questions about the final determination of whether a service or supply is covered, contact the appropriate claim administrator listed under "Other Plan Details" in *Rules and Regulations*.

The following items are generally excluded by all the medical coverage options offered by the corporation.

- Charges for services or supplies that are not needed or not appropriately provided, including any charges made in connection with those services or supplies. A service or supply is considered "needed and appropriately provided" if the insurance company determines that it meets each of the following requirements:
  - It is ordered by a doctor for the diagnosis or the treatment of a sickness or injury.
  - The prevailing opinion within the appropriate specialty of the U.S. medical profession is that it is safe and effective for its intended use and its omission would adversely affect the person's medical condition.
  - It is furnished by a provider with appropriate training, experience, staff, and facilities to furnish that particular service or supply.
- Charges for experimental or investigational services or supplies including any charges made in connection with those services or supplies. A service or supply is considered "experimental or investigational" if the insurance company determines that one or more of the following are true:
  - The service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis.
  - The prevailing opinion within the appropriate specialty of the U.S. medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.
- Charges for educational services or supplies and any charges made in connection with those services or supplies. Educational means:
  - the primary purpose of the service or supply is to provide training in the activities of daily living, scholastic instruction (reading or writing), job training or treatment for learning disabilities, or
  - the service or supply is being provided to promote development beyond any level of function previously demonstrated.

  "Training in the activities of daily living" does not include training directly related to treatment of a sickness or injury that resulted in a loss of a previously demonstrated ability to perform those activities. Any hospital services or supplies attributable to the scholastic education or vocational training of a patient are not covered.

- Custodial care—meaning care that provides a level of routine maintenance for the purpose of meeting personal needs, including long-term care. (It is care that can be provided by a lay person who does not have professional qualifications, skills, or training. It includes help in walking; getting into or out of bed; bathing; dressing; eating; applying medications, creams, or ointments; administering medical gases; providing routine care, including changing of dressings, diapers, and protective sheets; turning and positioning in bed; providing routine care and maintenance in connection with canes, braces, colostomy, and ileostomy bag and indwelling catheters; routine tracheostomy care; and supervising exercise programs, including those maintenance and repetitive exercises that do not need the skills of a trained therapist.)
- Cosmetic surgery—meaning surgery performed mainly to change a person's appearance. (Coverage is provided if the change in appearance is needed to treat a mental, psychoneurotic, or personality disorder. However, cosmetic surgery coverage does not include reconstructive surgery when it is incidental to or follows surgery resulting from trauma, infection, or disease, or is due to a birth disease or defect that impairs the function of a body organ, other than reconstructive surgery following a mastectomy, as required by law.)
- Charges incurred before coverage begins
- Services furnished by a member of your immediate family or household
- Any injury or disease caused by war or an act of war, declared or undeclared
- Transportation or travel by other than local ambulance service
- Any hospital or medical expenses for treatment of illness or injury in a governmental hospital or extended care facility or any subdivision or agency thereof, unless coverage under the plan is legally required
- Any costs for treatment, services, or supplies for a job-related illness or injury provided in or out of a hospital or in an extended care facility. (See "Workers' Compensation" in *Other Disability Coverage* for more information.)
- Charges that the covered person is not legally required to pay
- Impregnation or fertilization charges, including those that involve either a covered person or a surrogate as a donor or recipient of an actual or attempted impregnation or fertilization. (Most plans do not have coverage for these services or may have important limits on that coverage. For specific information on coverage, see the plan summary for each plan.)
- Eye examinations used to determine the need for (or change of) eyeglasses or lenses of any type except initial replacement for loss of the natural lens or following cataract surgery or damage to the natural eye as a result of injury. (Eye surgery for radial keratotomy when the primary purpose is to correct nearsightedness, farsightedness, or blurring is not covered.)
- Newborn child expenses, unless they are furnished in order to diagnose or treat an already diagnosed sickness, injury, congenital defect, or birth abnormality of that child
- Dental services charges—for doctors' services or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process, or the gums. (This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the treatment of temporomandibular joint (TMJ) disorders or malocclusion involving joints or muscles by such methods as crowning, wiring, or repositioning teeth—unless for the treatment or removal of a malignant tumor or an accidental injury to sound natural teeth within 12 months of the accident or exams and X-rays in connection with the treatment of TMJ disorders.)
- Chiropractic treatment that is primarily for maintenance purposes
- Services rendered to bypass a disease causing infertility to effect pregnancy

Long-Term Care

Although long-term care is not covered through the corporation's medical plans, the corporation offers long-term care coverage through a separate plan. See *Long-Term Care Insurance* in the *Other Benefits* section for more information.

- Charges for speech therapy, unless incurred to treat a covered disability or condition
- Charges for psychological testing, whether on an inpatient or outpatient basis

Point-of-Service (POS) Plan

A Point-of-Service (POS) plan offers a choice when you need medical care—you can go "in-network" by following the POS plan's procedures for accessing its network of healthcare providers, or you can go "out-of-network" and see any healthcare provider you choose. Generally, when you go in-network, you receive a higher level of benefits.

Your POS Options

See the plan summaries at *www.benefitsplanner.com* for details on the POS plans offered by the corporation.

The POS plan the corporation offers is the UnitedHealthcare POS Plan, which is available in most areas of the country.

This section provides a general summary of how a POS plan works. See the plan summaries at *www.benefitsplanner.com* for specific details on the UnitedHealthcare POS Plan.

In This Section **See Page**

How POS Plans Work

POS plans offer you a choice about how to receive your healthcare. Each time you need medical care—at the point of service—you decide which healthcare provider to see. You can receive care through the POS plan's network healthcare providers, or you can see a doctor or hospital not affiliated with the plan.

If you go out of network...

you have benefits, but you pay more out of your own pocket for this care.

If you receive care through a network provider (or follow other POS plan rules for accessing network care), you receive higher, "in-network" benefits. All charges provided by network providers are within reasonable and customary (R&C) limits. For more information, see "Reasonable and Customary."

If you go out of the plan network for care, you have benefits, but you pay more out of your own pocket for this care. In addition, the fees charged may be more than the R&C limits established by the plan.

For certain services, you must notify the plan in advance, and benefits are reduced or denied if you don't call when required. Usually, when you receive in-network care, your network primary care physician (PCP) or specialist notifies the plan for you. If you go outside the network for care, you are responsible for notifying the plan in advance.

POS plans may have rules and guidelines for the providers who participate in their network about how they explain treatment options to patients and may provide incentives to the participating healthcare providers based on the care their patients receive. The plans also may make arrangements with certain healthcare service providers for discounted services, and these savings may or may not be passed to you as a plan participant. If you would like additional information, please contact the POS plan directly.

You Choose In-Network or Out-of-Network

In-Network	Out-of-Network
See your PCP or a network specialist.	See any provider.
Pay only a copayment for most care, pay coinsurance for hospitalization and certain other kinds of care.	Pay the bill.
No claim forms to file.	File a claim form. The plan reimburses a percentage of your expense (after you satisfy the deductible), within R&C limits.

In-Network vs. Out-of-Network

In general, you receive in-network benefits if	In general, you receive out-of-network benefits if
▪ You see your network PCP or specialist. ▪ You go to any hospital emergency room (as long as it's a true emergency) and call your PCP or the plan within the required time frame.	▪ You see a provider who is not affiliated with the network. ▪ You go to a hospital emergency room and you do not need emergency care. (Some POS plans don't pay anything in this instance.) ▪ You go to a hospital emergency room and are admitted and do not call your PCP or the plan within the required time frame

Network Coverage

POS plans feature a network of selected doctors and hospitals that have agreed to provide medical care to plan participants. When you enroll in a POS plan, you select a PCP from a list of network doctors. Your PCP helps to coordinate your medical care.

How Benefits Are Paid

With most POS plans, care coordinated by your PCP is considered in-network care, so your out-of-pocket costs are lower.

For many in-network benefits, you pay only a copayment for in-network care; the plan then pays 100% of the remaining cost. For some network benefits, instead of a copayment arrangement the plan uses a coinsurance model, where the plan pays a percentage of the cost (for example, 90% of in-network hospitalization costs) and you pay the remainder.

For the in-network benefits that use a coinsurance model, the coinsurance benefit percentage is paid immediately—there is no deductible that must be met before the plan pays benefits for in-network care. Also, reasonable and customary (R&C) limits do not apply to in-network benefits, because the network providers' charges are based on pre-negotiated schedules that are within the R&C limits. Finally, you are protected from catastrophically high in-network expenses by an out-of-pocket maximum that limits the amount you and your family have to pay for covered in-network expenses in a given year.

For details on the benefits the UnitedHealthcare POS Plan provides, see the plan summaries at *www.benefitsplanner.com*. For an overview of copayments, coinsurance, and other factors that determine how benefits are paid, see "How Plans Work."

Note that the UnitedHealthcare POS Plan's in-network and out-of-network out-of-pocket maximums are counted separately—amounts that count towards your in-network out-of-pocket maximum do not count toward reaching the out-of-network out-of-pocket maximum, and vice versa.

Preventive Care

Most POS plans' in-network benefits cover preventive care such as physical exams, Pap smears, immunizations, and well-baby care. These preventive care services are not always covered if you receive them from out-of-network providers.

Primary Care Physicians

Your PCP acts as a guide to provide and coordinate all your in-network care.

When you enroll, every covered family member selects a primary care physician. You can find PCPs listed in the UnitedHealthcare POS Plan provider directory, available through the plan's Web site. If you like, you may select a different PCP for each family member.

For instance, your PCP could be a general practitioner, an internist, or a family practitioner. You may also choose a pediatrician as your children's PCP. Women may select a gynecologist for their routine gynecological checkups, in addition to choosing a PCP for other healthcare needs.

Changing Your PCP

You can change your PCP as often as you want. To change your PCP, notify UnitedHealthcare by calling 1-866-328-6575 or by accessing the plan's Web site.

Plan Provider Directories

To find network providers, see the plan summaries at *www.benefitsplanner.com* for links to the POS plan's online provider directory.

The Department of Labor requires that employers provide employees with "Summary Plan Descriptions" of certain benefit plans. Plan provider directories are an essential part of the Summary Plan Description for the POS plan. There are two other documents that complete the Summary Plan Description:

- This description in the Benefits Handbook
- The plan summary, available at *www.benefitsplanner.com*

If You Need a Specialist

You can see a specialist without obtaining a referral from your PCP.

If You See a Network Specialist

When you see a specialist who participates in the network, you generally pay only a copayment at the time you receive care; the plan pays the rest.

If You See an Out-of-Network Specialist

If you see an out-of-network specialist without a referral, coverage will be treated as out-of-network.

If your PCP obtains authorization for you to see a specialist or to go to a facility that is not part of the network, your care is still covered at the in-network level. However, when you see that specialist, you pay for the care you receive and file a claim for benefits.

Emergency Coverage

If you go to a hospital emergency room and your condition is not an emergency...

or if you do not notify your plan about the emergency within the required time frame, your benefits may be reduced or not paid at all.

In case of a medical emergency, the POS plan will provide in-network benefits even if you have to use a provider that is not part of the POS plan network, provided you meet the POS plan's emergency notification requirements.

A medical emergency is generally defined as a sickness or injury that, in the judgment of reasonable person, without immediate medical attention, could place a person's life in danger or cause serious harm to bodily functions. Examples of emergencies include an apparent heart attack, severe bleeding, loss of consciousness, and severe or multiple injuries.

If you have a life-threatening situation, go to the nearest emergency room. Show your ID card to the hospital admissions staff. To ensure you receive in-network benefits, you must contact the POS plan within two days (in most cases) of the medical emergency. (The plan will tell you if you also need to notify your PCP.) If you notify the plan, you receive in-network benefits, which generally means your care is covered at 100% after a copayment. (The copayment is waived if you are admitted through the emergency room.) If you do not notify the plan, you will receive out-of-network benefits. This means you will be reimbursed at the lower, out-of-network level. You will also have to pay a penalty for not notifying the plan of your emergency care. Check with your plan to see whether follow-up care is necessary.

Non-emergency services provided in the emergency room are not covered unless you are referred by your PCP or other network provider.

Filing a Claim

In most cases, it is not necessary to file a claim for in-network services because those expenses are automatically handled by the POS plan. Occasionally, however, you may be billed directly for covered services (such as laboratory tests, out-of-network physician referrals, or emergency care) that are authorized by your POS plan. If that happens, submit a claim form along with itemized bills to your POS plan. See "Filing a Claim" under "Out-of-Network Coverage" for more information.

Out-of-Network Coverage

As an alternative to having to use only network providers, you can go to any doctor you wish. You make this choice each time you need care. Following is a general summary of how out-of-network coverage works. The specific out-of-network coverage you receive depends on the POS plan. See the plan summaries at *www.benefitsplanner.com* for more information.

When you go to a physician who is not part of the POS plan's network, you receive out-of-network benefits. In general, out-of-network benefits use a coinsurance model, paying a percentage of the eligible charges for covered expenses after you pay a certain amount of your medical expenses, called your deductible. You are protected from catastrophically high out-of-network expenses by an out-of-pocket maximum, which limits the amount you and your family have to pay for covered expenses in a given year. However, out-of-network charges are subject to reasonable and customary (R&C) limits. If the charges for the services exceed the R&C limits, you are responsible for the excess amount, and amounts in excess of the R&C limit do not count towards your annual out-of-pocket maximum.

For certain kinds of care, you must notify the plan in advance. When you receive out-of-network services, it is your responsibility to notify the plan. Benefits are reduced if you don't notify the plan when required. See "Advance Notification" for more information.

For more details on how the benefits model described here works, see "How Plans Work."

How Benefits Are Paid

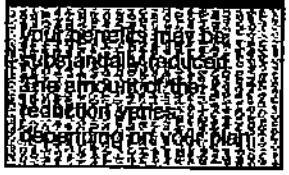
Here is a quick overview of how out-of-network benefits are paid:

- You satisfy a deductible each year—then...
- The plan will reimburse you a percentage of eligible charges based on reasonable and customary fee schedules—until...
- You reach the annual out-of-pocket maximum—then...
- The plan pays 100% of most covered expenses that you incur during the rest of the calendar year—up to...
- The maximum lifetime benefit.

Advance Notification

You must notify the plan in advance for certain kinds of healthcare. Advance notification (sometimes referred to as precertification) is designed to help protect you from the cost and inconvenience of unnecessary surgery or extended hospital stays. By calling in advance, you learn before you incur an expense whether your treatment is covered by the plan. In addition, it is important to notify the plan when necessary, or your benefits may be reduced.

If you do not notify the plan in advance when necessary...



To notify the UnitedHealthcare POS Plan in advance, call Care Coordination at 1-866-328-6575.

Here are the situations in which you must call:

- Inpatient admissions to a hospital, skilled nursing facility, or inpatient rehabilitation
- Emergency health services that result in an inpatient stay (if an emergency admission occurs, the member should call within two business days)
- Home healthcare services, including private duty nursing
- Hospice services
- Durable medical equipment (for items with a purchase/cumulative rental cost that exceeds $1,000)
- Reconstructive procedures
- Maternity services (if stay exceeds the 48/96-hour guidelines)
- Accidental dental services
- Transplant services

If you do not call before receiving the service, you will be subject to a $500 penalty. The first $500 of the expenses you incurred will not be reimbursed and any remaining expenses for healthcare services will be covered only at 70%.

Filing a Claim

If you're enrolled in the UnitedHealthcare POS Plan and a Healthcare FSA...

UnitedHealthcare will automatically "roll over" any amounts not paid and submit them for FSA reimbursement. Generally, you won't have to submit separate claims to be reimbursed for FSA-eligible expenses not covered by the medical plan. See *Healthcare Flexible Spending Account* in the *Flexible Spending Accounts (FSAs)* section for details.

When you receive out-of-network services, you are responsible for paying the full cost at the time you receive care. Then you must submit a claim form for reimbursement.

A separate claim form must be submitted for each family member, but you can include more than one expense on each form.

Claim forms are available:

- on The McGraw-Hill Companies Intranet,
- on the Web at *www.benefitsplanner.com*,
- from the HRSC at 1-888-THE-HRSC (1-888-843-4772), and
- from your POS plan at the number on your ID card.

Complete your section of the form as shown in the instructions. Submit your claim form along with itemized original bills (or copies if you submitted the bills to another insurer first) to the plan at the address on the form. Be sure to answer all questions to avoid delays in having your benefits paid.

If all of the bills you are submitting are from one doctor, ask him or her to complete, date, and sign the form, and to mail it to the address shown on the form. If you are submitting bills from more than one doctor, simply complete your section and send all your bills and the form to the address shown on the form.

If you have other coverage, there may be special rules and claims procedures that apply. See "If You Have Other Coverage" in *Participating in Healthcare Coverage* for information.

If you are not satisfied with the outcome of a benefits claim you have submitted you can ask that the claim be reviewed. See "Claims Review Process" in *Rules and Regulations* for information.

What's Covered

Prescription Drug and Mental Health/Chemical Dependency Coverage

The UnitedHealthcare POS Plan includes prescription and mental health benefits. See *Prescription Drug Coverage* and *Mental Health/Chemical Dependency Coverage* for more information.

This section describes, in general terms, the benefits that POS plans cover. See the plan summary at *www.benefitsplanner.com* for specific information on the benefits available from the UnitedHealthcare POS Plan.

Covered Health Services

POS plans pay benefits for services, treatment, supplies, and facilities that are covered health services (as determined by the POS plan). See "What's Not Covered" in *Medical Coverage* for additional information.

Not Sure If Your Expense Is Covered?

If you don't see a particular service listed in this section, check the list of excluded services under "What's Not Covered" in *Medical Coverage*. If you don't see the service listed here or under "What's Not Covered," call UnitedHealthcare 1-866-328-6575 determine whether the service is covered.

Outpatient Care

When you receive same-day care without an overnight hospital stay, your care is called outpatient or ambulatory care. For instance, if you go to a hospital emergency room to receive treatment for a broken bone, but you are not admitted to the hospital, that's outpatient care. Similarly, doctor's office visits and specialist visits are considered outpatient care. In some cases, such as outpatient surgery or emergency hospital care, you must notify the plan in order to receive maximum benefits.

See "Advance Notification" for more information.

Doctor's Office Visits

To receive in-network benefits, you must visit your PCP or a network specialist. Both in- and out-of-network benefits cover doctor's charges for

- hospital visits,
- surgery,
- anesthesia, and
- maternity care, including prenatal, delivery, and post-natal care.

Specialist Visits

POS plans cover doctor's office visits to specialists such as allergists, cardiologists, dermatologists, and neurologists. You can see a network specialist without a referral from your PCP, or your PCP may suggest that you see a specialist.

Preventive Care

Generally, in-network benefits cover preventive and wellness care. You may have to pay a copayment for the office visit. Any test or diagnostic procedure that your doctor orders may be subject to coinsurance. You do not have to meet a deductible for in-network care. Out-of-network benefits for preventive care vary by plan, but in some cases, you must meet the out-of-network deductible before the POS plan will pay a percentage of the covered expense. Be sure to check your coverage before receiving out-of-network care, as your plan may limit coverage for preventive and wellness care, or, in some instances, may not provide it at all.

Diagnostic Testing

POS plans cover eligible charges for diagnostic, preadmission, and post-admission testing, including lab tests and X-rays. Diagnostic testing may be subject to coinsurance.

Maternity Care

In-network and out-of-network benefits cover expenses related to pregnancy and childbirth. In-network care will be coordinated by your PCP or your OB/GYN.

Outpatient Surgery

If your surgeon (or other doctor primarily responsible for your inpatient treatment) is part of the POS network, you receive in-network benefits for surgery performed on an outpatient basis, including necessary services and supplies. However, outpatient surgery may be subject to coinsurance.

If your surgeon (or other doctor primarily responsible for your inpatient treatment) is not part of the POS network, the plan will pay out-of-network benefits for eligible charges related to hospital admissions, provided that the plan is notified in advance.

See the plan summaries at *www.benefitsplanner.com* for details.

The determining factor of your benefits is the treating physician, not the facility. If you are treated by a non-network physician, the benefits will be paid on an out-of-network basis, even if the treatment is provided in an in-network facility.

All surgery, whether as an inpatient or as an outpatient, may require precertification. Before scheduling any surgery you or your doctor should contact your plan.

Outpatient Therapeutic Services

POS plans cover outpatient therapeutic services that require ongoing care, such as the following:

- Speech therapy
- Physical/occupational therapy—Physical or occupational therapy is therapy used to correct impairments caused by an illness or injury. In general, physical and occupational therapy is covered only as long as the therapy continues to improve the level of functioning within a reasonable period of time. To be covered, the therapy must be provided to restore or help you regain body functions that were lost due to an illness or injury.
- Cardiac rehabilitation
- Chemotherapy
- Radiation therapy

Inpatient Care

If you stay overnight in a hospital or other healthcare facility, all care that you receive during your hospital/facility stay is called inpatient care. The plan requires advance notification of inpatient care, so be sure to call your plan before entering the hospital or other facility. In the case of an emergency, call within 48 hours. Benefits are reduced if you do not notify the plan within the required time frame. See "Advance Notification" for information.

Hospital/Facility Care

If your surgeon (or other doctor primarily responsible for your inpatient treatment) is part of the POS network...

- You receive in-network benefits for surgery or other services performed on an inpatient basis, including semi-private room and board, intensive care, and preadmission testing charges. Surgery may be subject to coinsurance.

If your surgeon (or other doctor primarily responsible for your inpatient treatment) is *not* part of the POS network...

- The plan will pay out-of-network benefits for eligible charges related to hospital/facility admissions, provided that the plan is notified in advance. See the plan summaries at *www .benefitsplanner.com* for details. Your benefits will be reduced if you do not notify the plan in advance.

The determining factor of your benefits is the admitting physician, not the facility. If you are admitted by a non-network physician, the benefits will be paid on an out-of-network basis, even if the treatment is provided in an in-network facility.

Care for Newborns and Their Mothers

Group health plans such as the ones offered by the corporation are regulated by federal law.

- The plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:
  - fewer than 48 hours following a normal delivery, or
  - fewer than 96 hours following a cesarean section.
- Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother (and subject to the mother's consent), from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- The plan may not require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

Some states may impose different rules for benefits provided in their state. Check with your plan regarding applicable rules for your state.

Also, some POS plans may offer an incentive to leave the hospital earlier, such as additional services that can be provided at home. However, these incentives must be offered on an optional basis, since you have legal rights as described above.

Notify the Plan for Higher Benefits

To receive the highest benefits possible, you must call UnitedHealthcare at 1-866-428-6515 to notify the plan regarding out-of-network hospital admissions (emergency or non-emergency).

If you do not notify the plan when necessary, your benefits may be reduced or denied. For more information, see "Advance Notification."

Emergency Care

POS plans cover emergency care both in- and out-of-network if you have an emergency as defined under "Emergency Coverage." Whenever you have inpatient surgery, or other inpatient hospital care (including emergency care), you must notify the plan within two days of the inpatient admission. See "Advance Notification" for more information.

Ambulance

POS plans cover professional ambulance service when necessary to transport a patient to the nearest hospital where appropriate treatment is available.

Hospital Emergency Room

Hospital emergency room treatment and associated hospital services are covered in- and out-of-network provided you need emergency medical treatment. Hospital emergency rooms are designed to be used only for emergency care. If you go to an emergency room for treatment and you do not need emergency medical care, your benefits may be substantially reduced. You may even be responsible for the full cost of care, as described under "Emergency Coverage."

Urgent Care Center

POS plans generally cover emergency care treated at an urgent care center. If you seek care from an urgent care center that is not part of the plan's network, you may be required to notify the plan in advance.

Other Services

When necessary, POS plans cover the following services both in- and out-of-network. Some services are subject to prior notification. See the plan summaries at *www.benefitsplanner.com* for details.

Home Healthcare

Medical assistance that patients can receive at home while recuperating from an illness or injury is called home healthcare. Covered medical assistance usually includes nursing care, home health aide services, and physical or occupational therapy. It usually does not include care provided by a person who doesn't have medical training, nor does it include custodial care—care that provides a level of routine maintenance for the purpose of meeting personal needs.

Chiropractic Care

Although POS plans generally cover chiropractic care both in- and out-of-network, some plans have limits on the out-of-network benefits they will provide.

Medical Supplies

The plan covers the cost of the following medical supplies:

- Prosthetics, braces, crutches, and artificial limbs or eyes. (Charges for their repair or maintenance are not covered, nor are replacements, unless necessary.)
- Renting an iron lung, oxygen tent, hospital bed, wheelchair, or similar durable medical equipment (see "Durable Medical Equipment," below)
- Local ambulance services
- Blood or blood plasma and its administration, unless replaced by a blood bank

Durable Medical Equipment

The plan covers eligible charges for durable medical equipment that is prescribed by your doctor. The plan decides whether to rent or purchase equipment.

Durable medical equipment refers to medical equipment and supplies that:

- can withstand repeated use,
- are not disposable,
- are used to serve a medical purpose,
- are not generally useful to a person in the absence of a sickness or injury, and
- are appropriate for use in the home.

Examples of durable medical equipment include standard wheelchairs, hospital beds, and oxygen and rental of equipment for administration of oxygen.

Hospice Care

Hospice care refers to services provided for a terminally ill person and his or her family members. Hospice care programs provide either home care or inpatient care through an affiliated hospital or nursing facility.

Health Maintenance Organizations (HMOs)

The corporation has entered into arrangements with a number of Health Maintenance Organizations (HMOs) to offer medical coverage to eligible employees. Most of the HMOs offered are fully insured plans, but some are self-insured by the corporation. The HMOs available to you will depend on your home ZIP code.

Your HMO Options

To find out which HMOs are available in your area see Employee Self-Service. To see a summary of each HMO, see the plan summaries at *www.benefitsplanner.com*. You can also see the *Healthcare Option Summaries* or call the HRSC.

In This Section **See Page**

Although HMOs generally deliver benefits in the same way, the coverage that each HMO provides is unique. To equip you with the information you need to understand the benefits a specific HMO offers, The McGraw-Hill Companies has the following materials:

- This section of the handbook provides a general description of how HMOs work and the medical benefits typically available to HMO participants. Reviewing this section will help you understand the detailed, HMO-specific information contained in the following three documents.
- For each HMO, there is a brief summary in the *Healthcare Option Summaries* available at *www.benefitsplanner.com*. This summary provides more specifics about the copayments and other details of covered services for the HMO.
- In addition to the brief summary, the *Healthcare Option Summary* for each HMO includes a link to a file of coverage details, typically containing a Certificate of Coverage and, for some HMOs, other documents that provide extensive information on the HMO's coverage. This file will generally have information concerning:
  - The kinds of services the HMO provides, including specifics on the benefits and limitations on benefits;
  - Conditions about your eligibility to receive such services (other than general conditions pertaining to eligibility to participate in the plan) and circumstances under which services may be denied; and
  - The procedures to be followed when obtaining services and the procedures available for the review of claims for services that are denied in whole or in part.
- The *Healthcare Option Summary* for each HMO also has a link to a provider directory for each HMO, so that you can identify the healthcare providers who participate in that HMO's network.

You should also review this handbook's *Rules and Regulations* section. *Rules and Regulations* provides you with information about your legal rights under ERISA, general information on claims review and appeals procedures, and other important administrative information. Also, for information on HMO eligibility, be sure to read the *Participating in Healthcare Coverage* section, which describes the eligibility rules for the corporation's medical plan through which the HMO coverage is offered.

All the materials described above make up the Summary Plan Description for the HMOs offered by The McGraw-Hill Companies.

How the Typical HMO Works

Generally, an HMO will cover only care that you receive from healthcare providers who participate in the HMO's network. (There are exceptions for emergency situations.) If you enroll in an HMO, you must use only those physicians, hospitals, and other providers who participate in that HMO's network. If you do not use participating providers—except in an emergency—the HMO will not cover that care, and you will be responsible for paying the full cost of that care.

With most HMOs, when you enroll you select one physician—your primary care physician (PCP)—to provide your routine and preventive care and to coordinate all your healthcare. In most cases, if you need to visit a specialist or be admitted to the hospital, the HMO (in many cases, through your PCP) will refer you to the HMO's specialists and facilities.

HMOs generally do not require you to file claims or pay a deductible before the HMO provides benefits. Instead, whenever you visit a doctor or other provider in the HMO's network you present the HMO ID card that you will receive from the HMO to show you are a member, and then you usually pay a small fixed fee, called a copayment, for your care.

The specific services that are covered will vary depending on the HMO you select. You can find more information about each HMO at *www.benefitsplanner.com*, in the *Healthcare Option Summaries*, or by contacting the HRSC.

Network Coverage

HMOs feature a network of selected doctors and hospitals that have agreed to provide medical care to plan participants. When you enroll in an HMO, you select a PCP from that network. You will find PCPs listed in your HMO's provider directory, which you can access from your HMO's Web site or by calling the phone number on your ID card. In most HMOs, for your treatment to be covered you must see your PCP first, so that he or she can coordinate your care.

HMOs may have rules and guidelines for the providers who participate in their network about the way they explain treatment options to patients. Your HMO may provide incentives to the participating healthcare providers based on the care their patients receive. The HMOs also may make arrangements with certain healthcare service providers for discounted services, and these savings may or may not be passed to you as a plan participant. If you would like information about patient communication guidelines, provider incentives, and provider discounts, please contact your HMO directly.

How Benefits Are Paid

With most HMOs, you don't need to file claims for benefits. You generally pay only a copayment each time you receive care. The plan covers the remainder of the cost.

A copayment is a predetermined fee (fixed dollar amount) that you pay for certain healthcare services. Generally, outpatient care is covered at 100% after you pay a copayment for each visit or service. Depending on the HMO, the copayment for specialist care may be higher than the copayment for care from your PCP or for outpatient preventive or diagnostic testing. In most HMOs, there is a higher copayment for care provided in an emergency room, but this copayment is often waived if you have to be admitted to the hospital. With many HMOs, inpatient care is covered at 100% with no copayment.

Occasionally, you may be billed directly for covered services (such as laboratory tests or emergency care) that are authorized by your PCP. If that happens, contact your HMO for instructions on how to file a claim for benefits.

Remember, except in emergency situations, the HMO only covers care received from providers who are part of the HMO network and requires that you have any necessary HMO approval for care such as specialist visits or inpatient care. The easiest way to ensure that you have the necessary approval is to have your PCP coordinate all the care you receive. If you are unsure about whether your care is approved and will be covered, call your HMO at the number on your ID card.

Maximum Benefits

For most HMOs and for most services, there is no annual or lifetime limit on the amount of benefits you receive from healthcare providers in your HMO's network. Limits may apply for certain kinds of care, and these limits are often defined in terms of how often you can receive the care within a fixed time period (or, for inpatient care, how many days of inpatient care are covered) See the plan summaries at *www.benefitsplanner.com* for more information about these limits.

Primary Care Physicians

Your PCP acts as a guide to provide and coordinate all of your care. If your PCP finds that you need special care, he or she will refer you to specialists and facilities that are part of your HMO's network.

When you enroll, every covered family member usually selects a primary care physician. You can find PCPs listed in your HMO's provider directory or in the HMO's plan summary at *www.benefitsplanner.com*. If you like, you may select a different PCP for each family member.

For instance, your PCP could be a general practitioner, an internist, or a family practitioner. You may choose a pediatrician to be your children's PCP. In some HMOs, women may select a gynecologist for their routine gynecological checkups, in addition to choosing a PCP for other healthcare needs.

Changing Your PCP

Most HMOs allow you to change your PCP when you want to—without waiting for annual enrollment. To change your PCP, contact your HMO by calling the phone number on your ID card.

If You Need a Specialist

Generally, when you need a specialist, you will have to obtain a referral from your HMO or you will not receive benefits. With most HMOs, your PCP is responsible for providing these specialist referrals.

In some HMOs you do not need a PCP referral to see a specialist, or referrals are not required for certain kinds of specialists for certain care. For example, many HMOs will allow women who participate in the HMO to see a network gynecologist for an annual checkup without a PCP referral. Some HMOs, often called "Open Access HMOs," do not require referrals at all, so long as the specialist you see is a member of your HMO's network. Call your HMO for details on this and other specialist care provisions.

If your plan requires a referral and you go to a specialist without one, you may be responsible for the full cost of your care.

What's Covered

Every HMO is different, so you should refer to the HMO-specific information available at *www.benefitsplanner.com* for details on what your HMO covers. You can also contact your HMO directly at the phone number shown on the plan summary or on your ID card to confirm what services are covered and whether there are any limits on coverage.

In an HMO, you must use providers and facilities that participate in the plan's network. If you do not, you will be responsible for the full cost of your care, except in an emergency.

If your HMO doctor recommends a service that is not covered by your HMO, but he or she feels that service is appropriate, he or she should notify you in advance that the HMO would not cover the care.

Routine Care

Most HMOs cover preventive care services and health screenings. Such services may include:

- routine physical exams, including well child care and adult care,
- routine health screenings, including gynecological exams, mammograms, sigmoidoscopy, colonoscopy, and PSA (prostatic-specific antigen) screenings,
- routine eye exams, or
- routine hearing exams.

Hospital Care

Generally, care in a hospital that is part of the HMO's network—both inpatient and outpatient—requires a copayment. After your copayment, hospital care is covered at 100% for covered services. If you use a network provider or lab but are not referred by your PCP, you may be required to pay for the services. Hospital services generally require a referral or advance approval from your HMO. Your PCP usually coordinates this precertification.

Maternity Care

Most HMOs cover physician services and hospital care for both the mother and the newborn child, including prenatal care, delivery, and post-natal care. Generally, you will need a referral for your first visit to a participating obstetrician. However, you will not need a referral for the remaining visits during your pregnancy.

The mother and newborn child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery and 96 hours following a cesarean section. Some HMOs provide coverage for home health care visits if your doctor determines (with the mother's consent) that you and your child may be safely discharged after a shorter stay.

State Maternity Laws

The 48/96-hour minimum stay after childbirth is required by federal law. State laws may provide additional requirements for maternity coverage. See *www.benefitsplanner.com* for the information on your HMO and details on whether state requirements supersede the federal requirements.

Emergency Care

Most HMOs define a medical emergency as a sickness or injury that, without immediate medical attention, could place a person's life in danger or cause serious harm to bodily functions. Examples of emergencies include an apparent heart attack, severe bleeding, loss of consciousness, and severe or multiple injuries.

Most HMOs require a copayment for each emergency room visit. If you are admitted to the hospital, in most cases the copayment is waived. Non-emergency services provided in an emergency room are not covered.

See *www.benefitsplanner.com* for more information, including your HMO's definition of a true medical emergency.

If you have a life-threatening situation, go to the nearest emergency room. Show your HMO ID card to the hospital admissions staff. To ensure you receive benefits, most HMOs require that you notify the HMO within two days of the emergency. If you notify the HMO, your care will generally be covered at 100% after a copayment. If you do not notify the HMO, the HMO may not cover the cost of the care. This means you may be responsible for the full cost of your care.

If you go to a hospital emergency room and your condition is not an emergency...

or if you do not notify your HMO about the emergency within the required time frame, your benefits may be reduced or not paid at all.

Benefit Limitations

Covered services, exclusions, and limitations vary by HMO. It is important to check directly with the HMO before enrolling to ensure that you fully understand the provisions of the plan.

Traditional Indemnity Plan

Options in Your Area

The McGraw-Hill Companies Medical Plan is available only in areas where the corporation is not able to offer POS coverage. For a list of the medical care options offered in your area and a summary of each of those options, see Employee Self-Service and the plan summaries at *www.benefitsplanner.com*. You can also see the *Healthcare Option Summaries* or call the HRSC.

Under The McGraw-Hill Companies Medical Plan, a traditional indemnity plan, you may use any medical provider. After you satisfy an annual deductible, the plan reimburses you a certain percentage of the reasonable and customary charges for covered expenses.

The McGraw-Hill Companies Medical Plan is available only in areas where the corporation does not offer a Point-of-Service (POS) option.

In This Section

How the Plan Works

Here is a quick overview of how The McGraw-Hill Companies Medical Plan pays benefits:

- See your doctor—then...
- You pay in full for all services received and file a claim form—then...
- You submit a claim form for reimbursement—then...
- The plan will reimburse you a percentage of eligible charges (based on reasonable and customary fee schedules) once you meet the deductible for the year—then...
- If you reach the annual out-of-pocket maximum, the plan then pays 100% of most covered expenses that you incur during the rest of the calendar year, up to the lifetime maximum benefit.

For more details on the reasonable and customary fee schedule, deductibles, out-of-pocket maximums, and lifetime maximums, see "How Plans Work." For the current deductibles, out-of-pocket maximums, and lifetime maximum that apply under The McGraw-Hill Companies Medical Plan, see the plan summary at *www.benefitsplanner.com*.

Care Coordination: Advance Notification

If you do not notify Care Coordination...

your benefits may be substantially reduced.

You must notify the plan in advance for certain kinds of healthcare. Advance notification (sometimes referred to as precertification) is designed to help protect you from the cost and inconvenience of unnecessary surgery or extended hospital stays. By calling in advance, you learn before you incur an expense whether your treatment is covered by the plan. In addition, it is important to notify the plan when necessary, or your benefits may be reduced.

UnitedHealthcare manages the advance notification program for The McGraw-Hill Companies Medical Plan through Care Coordination. Call Care Coordination at 1-866-328-6575. Here are the situations in which you must call:

- Inpatient admissions to a hospital, skilled nursing facility, or inpatient rehabilitation
- Emergency health services that result in an inpatient stay (if an emergency admission occurs, the member should call within two business days)
- Home healthcare services, including private duty nursing
- Hospice services
- Durable medical equipment (for items with a purchase/cumulative rental cost that exceeds $1,000)
- Reconstructive procedures
- Maternity services (if stay exceeds the 48/96-hour guidelines)
- Accidental dental services
- Transplant services

If you do not call before receiving the service, you will pay a $500 penalty and benefits will be covered only at 70%.

Care Coordination: Alternate Benefits

If you or your family members suffer from a severe illness or injury that requires extensive specialized care, the Care Coordination feature (sometimes referred to as medical case management) can help you find appropriate alternatives to hospitalization. Examples of injuries and illnesses that are suitable for this program are:

- head injuries,
- extensive burns,
- spinal cord injuries, and
- comas.

UnitedHealthcare professionals identify those cases that are appropriate for medical case management through the continued stay review process. They work with you, your family, and your doctor to develop an alternative plan. The plan might include transferring the patient from a hospital to a convalescent or rehabilitation facility, or purchasing equipment to facilitate recovery at home.

The plan pays "alternative benefits" for care arranged through Care Coordination. Alternative benefits means that, if the insurance company determines that you have a catastrophic illness or injury, the plan may pay for services and supplies that normally wouldn't be covered by the plan as alternative treatment. These alternative services and supplies must be determined in advance by the insurance company to be medically appropriate and cost effective in meeting the long-term or intensive care needs of a person in connection with the illness or injury.

You can contact Care Coordination at 1-866-328-6575.

Filing a Claim

If you're enrolled in a Healthcare FSA...

UnitedHealthcare will automatically "roll over" any amounts not paid and submit them for FSA reimbursement. Generally, you won't have to submit separate claims to be reimbursed for FSA-eligible expenses not covered by this medical plan. See *Healthcare Flexible Spending Account* in the *Flexible Spending Accounts (FSAs)* section for details.

When you receive services, you must pay the full cost at the time you receive care, then submit a claim form for reimbursement.

When to File a Claim

Each year, you should file your first claim when your medical bills equal at least the amount of your deductible plus $50. After that, submit claims when your bills equal at least $50. Your last claim of the year may be for any amount of unpaid medical bills. To be reimbursed, you must submit all bills for the calendar year by December 31 of the following year. For example, you must submit all 2004 claims by December 31, 2005.

Completing Your Claim

A separate claim form must be submitted for each family member, but you can include more than one expense on each form.

Claim forms are available:

- on The McGraw-Hill Companies Intranet,
- on the Web at *www.benefitsplanner.com*,
- from the HRSC at 1-888-THE-HRSC (1-888-843-4772), and
- from UnitedHealthcare at 1-866-328-6575.

Complete your section of the form as shown in the instructions. Submit your claim form along with itemized original bills (or copies if you submitted the bills to another insurer first) to the plan at the address on the form. Be sure to answer all questions to avoid delays in having your benefits paid.

If all of the bills you are submitting are from one doctor, ask him or her to complete, date, and sign the form, and to mail it to the address shown on the form. If you are submitting bills from more than one doctor, simply complete your section and send all your bills and the form to the address shown on the form.

If you have other coverage, there may be special rules and claims procedures that apply. See "If You Have Other Coverage" in *Participating in Healthcare Coverage* for information.

If you are not satisfied with the outcome of a benefits claim you have submitted you can ask that the claim be reviewed. See "Claims Review Process" in *Rules and Regulations* for information.

What's Covered

This section describes the benefits covered by The McGraw-Hill Companies Medical Plan. The specific coverage amounts provided by the plan are shown in the plan summaries at *www.benefitsplanner.com*.

Covered Health Services

The plan pays benefits for services, treatment, supplies, and facilities that are covered health services (as determined by the plan). See "What's Not Covered" in *Medical Coverage* for additional information.

Not Sure If Your Expense Is Covered?

If you don't see a particular service listed in this section, check the list of excluded services under "What's Not Covered" in *Medical Coverage*. If you don't see the service listed here or under "What's Not Covered," call UnitedHealthcare at 1-866-328-6575 to determine whether the service is covered.

Prescription Drug and Mental Health/Chemical Dependency Coverage

The McGraw-Hill Companies Medical Plan includes these types of benefits. See *Prescription Drug Coverage* and *Mental Health/Chemical Dependency Coverage* for more information.

Outpatient Care

When you receive same-day care without an overnight hospital stay, your care is called outpatient or ambulatory care. For instance, if you go to a hospital emergency room to receive treatment for a broken bone, but you are not admitted to the hospital, that's outpatient care. Similarly, doctor's office visits and specialist visits are considered outpatient care. In some cases, such as outpatient surgery or emergency hospital care, you must notify the plan in order to receive maximum benefits.

See "Care Coordination: Advance Notification" for more information.

Doctor's Office Visits

The plan covers the following doctor's charges:

- The fees charged by licensed physicians, chiropractors, and podiatrists
- Chiropractic service if not considered maintenance
- Acupuncture if administered by a physician
- The cost of dental treatment in case of accidental injury that occurs to natural teeth while the individual is insured by the plan

Preventive Care

The plan covers annual physicals, well-child care, and certain preventive care screening tests. Covered preventive care services are covered on the same basis as other covered services and are subject to deductibles and reasonable and customary charge limits.

Diagnostic Testing

The plan covers eligible charges for diagnostic testing, including lab tests and X-rays.

Maternity Care

The plan covers expenses related to pregnancy and childbirth. This includes birthing centers.

Outpatient Surgery

The plan covers surgery performed on an outpatient basis and necessary medical services and supplies.

Outpatient Therapeutic Services

The McGraw-Hill Companies Medical Plan covers outpatient therapeutic services that require ongoing care, such as the following:

- Speech therapy

- Physical/occupational therapy—Physical or occupational therapy is therapy used to correct impairments caused by an illness or injury. In general, physical and occupational therapy is covered only as long as the therapy continues to improve the level of functioning within a reasonable period of time. To be covered, the therapy must be provided to restore or help you regain body functions that were lost due to an illness or injury.
- Cardiac rehabilitation
- Chemotherapy
- Radiation therapy

Inpatient Care

Don't Forget to Notify the Plan for Higher Benefits

To receive the highest benefits possible, you must notify the plan when you receive inpatient care.

If you do not notify the plan when necessary, your benefits may be reduced.

See "Care Coordination: Advance Notification" for more information.

The plan covers the following hospitalization charges:

- Pre-admission testing (80% coverage for the outpatient facility, and for pre-admission diagnostic testing if performed within seven days before the patient enters the hospital for that condition)
- Laboratory, X-ray, and radiotherapy services approved by your physician. (If these services are part of pre-admission testing, the cost is covered at 80%.)
- Room and board for semi-private hospital accommodations for treatment of illness, injury, or pregnancy up to 365 days per illness. (Care Coordination must be notified in advance about the hospital stay, or notified within 48 hours of an emergency admission. Special limitations apply to chemical dependency care in a hospital or an outpatient department licensed or approved for such treatment; see "Mental Health and Chemical Dependency" for further details. Except for mental health and chemical dependency, you are covered for each separate hospital admission up to 365 days provided it is separated by one day's return to full-time work if you are the patient or by complete recovery if your family member is the patient.)
- A semi-private hospital room (cost may also be applied to a private room)
- Intensive care
- While you or a family member is a hospital inpatient, the plan covers the following:
  - Treatment rooms
  - Drugs and medicines, including injections
  - Dressings
  - Splints and casts
  - X-rays and their interpretation
  - Reading of EKGs and pathological reports
  - Diagnostic laboratory services
  - Oxygen and its administration
  - Radiation therapy and treatment
  - Physical therapy
- Professional nursing services of a Christian Science nurse are included on the same basis as those for other nursing services, provided the nurse is listed in a current Christian Science Journal as having:
  - completed training at the Christian Science Benevolent Association Sanitarium,
  - been a graduate of another nurses' training course, or

- completed three consecutive years of Christian Science Nursing, including two years of training.

Inpatient Surgery

The plan covers inpatient surgery.

Maternity Care

Group health plans such as the ones offered by the corporation are regulated by federal law.

- The plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:
  - fewer than 48 hours following a normal delivery, or
  - fewer than 96 hours following a cesarean section.
- Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother (and subject to the mother's consent), from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- The plan may not require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

Some states may impose different rules for benefits provided in their state. Check with your plan regarding applicable rules for your state.

Emergency Care

The plan covers emergency care. Whenever you have inpatient surgery or other inpatient hospital care (including emergency care), you must notify the plan by calling Care Coordination at 1-866-328-6575 within two days of the inpatient admission.

See "Care Coordination: Advance Notification" for more information.

Ambulance

The plan covers professional ambulance service when necessary to transport a patient to the nearest hospital where appropriate treatment is available.

Hospital Emergency Room

Hospital emergency room treatment and associated hospital services are covered if you need emergency medical treatment. Within 48 hours of receiving emergency room care, you or someone else must call Care Coordination at 1-866-328-6575.

If you fail to call, you will be subject to a $500 penalty. See "Care Coordination: Advance Notification" for more information. If you go to the emergency room for non-emergency services, the plan will not cover the cost of services provided.

Urgent Care Center

The plan covers emergency care provided at an urgent care center.

Other Services

The plan pays a percentage of the R&C charges for the following therapy and home care charges:

- Hearing aids, limited to one appliance per ear every 24 months

- Physical therapy and occupational therapy
- Speech therapy to restore speech lost or impaired due to surgery, radiation therapy or other treatment which affects the vocal cords; cerebral thrombosis (cerebral vascular accident); or accidental injury which occurs while covered by the plan. Therapy is limited to 20 visits per calendar year.
- Private duty nursing care by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse, subject to preauthorization by Care Coordination
- Alternatives to long-term hospital care, subject to preauthorization with Care Coordination, including:
  - Home healthcare. (Coverage includes up to 60 visits from a licensed home healthcare agency. Covered services include part-time or intermittent nursing care by a registered nurse (RN), a licensed practical nurse (LPN), a public health nurse, a licensed vocation nurse under the supervision of an RN or an aide working for a licensed home healthcare agency.)
  - Confinement in a skilled nursing facility (including convalescent inpatient facilities) for up to 120 days in a calendar year
  - Inpatient rehabilitative therapy for up to 60 days per calendar year
  - Hospice care for up to 180 days lifetime maximum. Bereavement counseling is available within six months of the death of a patient and has a 15-visit maximum.

Medical Supplies

The plan covers the cost of the following medical supplies:

- Prosthetics, braces, crutches, and artificial limbs or eyes. (Charges for their repair or maintenance are not covered, nor are replacements, unless necessary.)
- Renting an iron lung, oxygen tent, hospital bed, wheelchair, or similar durable medical equipment (see "Durable Medical Equipment," below)
- Local ambulance services
- Blood or blood plasma and its administration, unless replaced by a blood bank

Durable Medical Equipment

The plan covers eligible charges for durable medical equipment that is prescribed by your doctor. The plan decides whether to rent or purchase equipment.

Durable medical equipment refers to medical equipment and supplies that:

- can withstand repeated use,
- are not disposable,
- are used to serve a medical purpose,
- are not generally useful to a person in the absence of a sickness or injury, and
- are appropriate for use in the home.

Examples of durable medical equipment include standard wheelchairs, hospital beds, and oxygen and rental of equipment for administration of oxygen.

Prescription Drug Coverage

All the corporation's medical options include prescription drug coverage. Your prescription drug benefits may depend on factors such as:

- the medical option you select,
- whether the prescribed drug is on the plan formulary,
- whether you purchase generic or brand-name drugs, and
- whether you fill your prescription in-network, out-of-network, or by mail.

This section describes standard prescription drug benefits. For more information on the benefits offered through your medical plan, see the plan summaries at *www.benefitsplanner.com*.

In This Section **See Page**

How Prescription Drug Benefits Work

When you enroll for medical coverage, you may receive a separate ID card for prescription drug coverage. You will need to present this card at the time you fill your prescription.

Network Coverage

In some medical plans, your prescription drug benefits depend on whether or not you fill your prescription at a pharmacy in the plan's network.

Network Pharmacies

Generally, when you go to a pharmacy that is part of the plan's network, eligible prescription drugs are covered at 100% for up to a 30-day supply after you pay a copayment. The copayment amount varies by plan and may depend on whether you purchase generic or brand-name drugs. See the chart under "Copayments" for details.

Out-of-Network Pharmacies

If you are enrolled in the UnitedHealthcare POS Plan, The Aetna (Self-Insured) HMO, or The McGraw-Hill Companies Medical Plan, your prescription drugs are provided by Medco Health. You can fill your prescriptions at a pharmacy that is not part of the network, but you will have to meet a separate deductible before any benefits are paid. You are responsible for the full cost up front and then must file a claim for reimbursement. The plan pays the cost submitted, less the applicable copayment amount, after you meet a separate $50 deductible. See the chart under "Copayments" and the plan summaries at *www.benefitsplanner.com* for details.

Most HMOs do not cover drug prescriptions filled at out-of-network pharmacies. See the plan summaries at *www.benefitsplanner.com* for details.

Copayments

For most plans, you pay for your prescription with a copayment. Copayments for many HMOs generally follow a standard three-tier schedule, based on whether the prescription is filled with a:

- generic drug,
- brand-name drug on the plan's formulary, or
- brand-name drug not on the plan's formulary.

Prescription drug benefits for the UnitedHealthcare POS Plan, the Aetna (Self-Insured) HMO, and The McGraw-Hill Companies Medical Plan are administered by Medco Health. See the plan summaries at *www.benefitsplanner.com* for prescription drug copayment information for all the medical plans offered by The McGraw-Hill Companies, including HMOs.

Generic vs. Brand-Name Drugs

In most plans, you will save on out-of-pocket costs if you have your prescriptions filled with generic, instead of brand-name, drugs. By law, generic and brand-name drugs must contain the same active ingredients and are subject to Food and Drug Administration (FDA) standards for quality, strength, potency, identity, and purity. The FDA also assures that generic drugs will have the same therapeutic effect as the brand-name drug under all approved indications and conditions of use.

Formulary Drugs

A formulary is the list of drugs the medical plan recommends for most prescriptions. Formulary lists are based on proved treatment effectiveness, cost compared with other medications, and other factors.

Pharmacy plans select specific drugs in major therapeutic classes for inclusion on their formularies. With most plans, if your physician writes a prescription for a formulary drug, your copayment will be less than if the prescription calls for a non-formulary drug.

If you're uncertain about whether a particular drug is on the formulary, check with your plan, using the plan contact information in the plan summary at *www.benefitsplanner.com*.

Mail-Order Prescriptions

If you have a chronic condition that requires ongoing medication, you may have access to a mail-order program that can provide you with a long-term supply of prescription drugs at lower cost. Examples of chronic conditions include arthritis, high blood pressure, diabetes, and allergies.

Using the mail-order program is both cost-effective and convenient. When you use the mail-order feature, you pay a copayment for up to a 90-day supply of most medications, and minimize your out-of-pocket costs for prescription drugs. What's more, once you've filled out your first mail-order application, you can usually order refills automatically with most major credit cards.

For more information about mail-order prescription drugs, including examples of how mail-order can help you save, visit *www.benefitsplanner.com*.

Mental Health/Chemical Dependency Coverage

You have two options when you or a covered family member needs mental health/chemical dependency care:

- The Employee Assistance Program (EAP), which is a free, confidential counseling service that is available to all employees, even if you do not elect medical coverage from the corporation. See *Employee Assistance Program* in the *Other Benefits* section for information or call the EAP at 1-800-544-8320.
- The mental health/chemical dependency benefits that you receive when you enroll for coverage from one of the medical options offered through the corporation.

Mental Health/Chemical Dependency Benefits through Your Medical Plan

All the corporation's medical plans include mental health and chemical dependency coverage. You don't have to enroll separately for this type of coverage.

The plan summaries show the specific mental health/chemical dependency benefits offered through each plan, including any copayment or deductible amounts. View your plan summary at *www.benefitsplanner.com* for specific information.

Most plans make a distinction between inpatient and outpatient mental health and chemical dependency care and provide different benefits for each type of care. Inpatient and outpatient benefits have limits on care, generally based on the number of outpatient visits and the number of days of inpatient care. Be sure to check your plan summary at *www.benefitsplanner.com* for your plan's specific limits before receiving care. In general, limits on your mental health and chemical dependency benefits will apply when you receive care from a mental health or chemical dependency provider. Medical benefit limitations apply when you receive care from other providers.

To determine whether the care you need is covered as mental health or chemical dependency care, contact your medical plan.

The EAP Is Available

Remember that in addition to the mental health/chemical dependency coverage offered through your medical plan, you also have access to the EAP. The EAP is a free service that offers short-term counseling for mental health/chemical dependency issues. You may want to seek help through the EAP before using benefits through your medical plan because the EAP services are free.

The EAP is available at 1-800-544-8320.

Dental Coverage

Good dental habits are an important part of safeguarding your general health. They also can help you reduce dental bills. The dental coverage available from the corporation is designed to encourage good preventive care to help you maintain healthy teeth and gums. The program also helps you pay for a broad range of other dental services when treatment is needed.

In This Section **See Page**

The corporation's dental coverage is provided through the Group Dental Insurance Plan. Under this plan, you may have a choice of two dental options to help you pay for your dental care needs:

- **The McGraw-Hill Companies Dental Plan**, which covers you regardless of which dentist you use and generally provides a lower level of benefits than the DMO Dental Plan. This plan also offers you access to a network of dentists who will provide care at pre-negotiated fees. Although you are not required to use network providers, your out-of-pocket cost will generally be less if you use dentists in this network than if you use providers who are not in the network.
- **The DMO Dental Plan**, which provides coverage through a network of dentists. In some cases, benefits are higher in the DMO Dental Plan than in The McGraw-Hill Companies Dental Plan. You must use DMO network providers in order to receive benefits from the plan.

Covering Uncovered Costs

The McGraw-Hill Companies Dental Plan has an annual maximum benefit that limits how much you can receive each year for covered dental expenses. Once you reach this maximum, you pay the full cost for all services for the remainder of the calendar year.

To help you pay dental charges that exceed the annual maximum (or to help you pay for your dental care if you decide not to enroll in one of the dental plans), you can set aside money in a Healthcare Flexible Spending Account (FSA). With a Healthcare FSA, you reimburse yourself for eligible healthcare expenses, including dental expenses, with money you contribute to the account on a pre-tax basis.

See *Flexible Spending Accounts* for more information.

Your Dental Options

For More Information

You can find your costs for coverage:

- on the Internet at *www.benefitsplanner.com*,
- on The McGraw-Hill Companies Intranet, or
- by contacting the HRSC.

The McGraw-Hill Companies offers two dental options:

- The McGraw-Hill Companies Dental Plan—This is a traditional indemnity plan that pays a portion of your covered dental expenses after you satisfy an annual deductible. You are eligible for benefits regardless of which dentist you see. However, the plan offers you access to a network of preferred dental care providers who will provide care at pre-negotiated fees. If you use dentists in this network, your out-of-pocket costs will generally be less than if you use non-network providers.
- The DMO Dental Plan—This plan gives you access to a network of dentists and other healthcare providers committed to giving quality care at a reasonable cost. You are only eligible for benefits when your care is provided by a network dentist (except in an emergency).

You also have the option to waive dental coverage from the corporation.

For more information about your dental coverage options, including a comparison of the two options, the dental plan summaries, an example of how the dental Preferred Provider Organization (PPO) works, and more, visit *www.benefitsplanner.com*.

The McGraw-Hill Companies Dental Plan

The McGraw-Hill Companies Dental Plan is a traditional indemnity plan designed to pay a portion of covered dental expenses for you and your family. To make it easier for you to avoid serious dental problems, the plan pays benefits for preventive care without any deductible.

To help you save on the cost of your dental care, the plan also offers you access to a network of dental care providers who have agreed to provide care at reduced rates—the Dental PPO.

How the Plan Works

With The McGraw-Hill Companies Dental Plan, you have coverage regardless of which licensed dental care provider you use. When you use PPO network providers, their lower pre-negotiated fees will help you save on your dental care.

The plan reimburses you for a percentage of the reasonable and customary amounts for covered dental services after you satisfy the annual deductible, if applicable. The maximum benefit you can receive is $1,500 per covered person per calendar year for covered services other than orthodontia and $2,000 per covered person per lifetime for orthodontic services.

Deductibles

The annual deductible is the amount you and each covered family member must pay each calendar year for covered expenses before the plan begins to pay benefits. After you satisfy the annual deductible requirement, the plan reimburses a percentage of covered expenses.

An individual deductible applies separately to you and to each of your covered family members, up to a family maximum.

A new deductible applies each calendar year.

The individual deductible is $75 per person each calendar year. There is no deductible for preventive dental services.

Family Deductible

To help limit the number of individual deductibles a family must meet each year, there is a family deductible. A family deductible is the total amount you and your covered family members have to pay in deductibles for the plan each year, regardless of the size of your family. When your family satisfies the annual family deductible, the plan begins to pay its share for your entire family's covered medical expenses for the remainder of the calendar year.

Here's how the plan determines whether your family has satisfied the family deductible.

- The amount of each family member's individual expenses (up to the individual deductible amount) counts toward the family deductible.
- No more than the individual deductible amount per person can be counted toward the family deductible.

The family deductible is $150 per calendar year.

Coinsurance

Once you meet the deductible, the plan pays a percentage (80% or 50%, depending on the service) of the reasonable and customary charges for most covered expenses. The remaining percentage that you pay – 20% or 50% – is called your coinsurance.

Note that if the cost exceeds the amount that the plan considers reasonable and customary (R&C) for a given service or procedure, the plan will base its coinsurance determination on the R&C amount. So if your care provider charges more than the R&C amount, you pay 100% of the additional cost.

Reasonable and Customary Charges

Reasonable and customary (R&C) charges (sometimes referred to as usual and prevailing charges) are based on the normal range of fees charged by providers of similar standing (for example, with similar training and experience) in the same locality for treatment, services, or supplies for a similar condition, illness or injury. The plan updates the R&C amounts regularly.

The plan covers only R&C charges. If your dentist's fees are more than the R&C charges, you are responsible for paying the portion that is greater than the R&C charge. Charges that exceed the R&C amount do not count toward your deductible.

Maximums

The maximum reimbursement you can receive each calendar year for covered dental services—other than orthodontic services—is $1,500 per covered person. Once you reach the $1,500 maximum, you pay the full cost for all services for the remainder of the calendar year.

There is a separate lifetime limit of $2,000 per covered person for orthodontic services.

How the PPO Network Works

Is my dentist in the PPO?

To find out whether your dentist participates in the Dental PPO network, or to find a dentist who does, call 1-800-645-5475 or visit *www.aetna.com/docfind* for a list of network dentists in your area.

The McGraw-Hill Companies Dental Plan PPO is a group of selected dental care providers who have agreed to offer care to participants in The McGraw-Hill Companies Dental Plan at pre-negotiated rates. These rates are generally lower than the fees non-network dentists charge for the same services. In addition, the pre-negotiated rates are always within The McGraw-Hill Companies Dental Plan R&C limits, so you never have to worry about whether you will be responsible for paying 100% of amounts over the R&C charges.

Using the Dental PPO is simple. If you enroll in The McGraw-Hill Companies Dental Plan, you will receive a dental ID card in the mail soon after you enroll. If your dentist is in the Dental PPO network, you will need to advise him or her that you are in the PPO plan and present your ID card whenever you receive dental care. Once your dentist knows you are part of the plan, your dentist will charge you the network rates for whatever care you receive.

You don't have to enroll separately in the Dental PPO—you can automatically use this feature if you are enrolled in The McGraw-Hill Companies Dental Plan.

How the PPO Helps You Save

How does the PPO help you save? It's simple—your share of the cost of your dental care is the same whether or not you use the PPO. But you save with the PPO because, **although the percentage you pay is the same, PPO network dentists charge lower prices.**

The lower PPO prices make the most difference when you're facing an expensive procedure or one of the special treatments where the plan's reimbursement rate is less than the usual 80% for basic services. If, for example, you or a member of your family needs restorative services (caps, crowns, dentures, etc.) or orthodontia, and the PPO dentist's charges are $160 less than a non-network dentist's fees, you could save $80 by using the PPO provider.

	Non-Network Dentist	PPO Network Dentist
Dental care (covered at 50%)	$800	$640
Plan pays 50%	$400	$320
You pay 50%	$400	$320

Your out-of-pocket savings = $80

This example assumes that you have met the deductible (which is the same whether or not you use Dental PPO dentists), and that the non-network dentist's charges fall within R&C limits. With PPO dentists, the pre-negotiated fees are always within the R&C limits.

What's Covered Under The McGraw-Hill Companies Dental Plan

The plan pays a percentage of your dental bills, according to the work done.

Preventive Services

Hygienists' Services

Hygienists' services are covered only if the hygienist is under a dentist's or physician's supervision.

The plan pays 100% of R&C charges for the following services with no deductible:

- Routine exams (up to twice a year)
- Bitewing X-rays (up to twice a year)
- Full mouth X-rays (up to once every 36 months)
- Cleanings (up to twice a year) and scalings
- Fluoride treatments for individuals under age 19 (up to twice a year)

Basic Services

The plan pays 80% of R&C amounts for the following services, after you meet the deductible. You pay the remaining 20%, plus any charges over the R&C amount:

- Fillings
- Removal of impacted teeth
- Oral surgery
- Anesthetics (in conjunction with oral surgery)
- Treatment of the gums (periodontics)
- Root canal therapy and other endodontic care

Restorative Services

The plan pays 50% of R&C amounts for the following services, after you meet the deductible. You pay the remaining 50%, plus any charges over the R&C amount:

- Caps and crowns
- Bridges and dentures (prosthodontics)

Orthodontic Services

The plan pays 50% of R&C charges for orthodontic services (for example, braces, retainers, and teeth-straightening devices). You pay the remaining 50%, plus any charges over the R&C amount.

If you are eligible for benefits for orthodontic services, you will receive a series of benefit payments, rather than one lump-sum benefit. The first payment is made when the appliances are first installed. The amount of this first payment is double the amount of the other benefit payments you will receive. Your remaining benefit payments are prorated based on the estimated duration of the orthodontic treatment, with payments to you every three months. If the actual charges turn out to be more or less than anticipated, the last benefit payment is adjusted accordingly.

What's Not Covered Under The McGraw-Hill Companies Dental Plan

The McGraw-Hill Companies Dental Plan does not cover the following treatments and services:

- Services considered medically unnecessary by the insurance company
- Treatment of injury or disease resulting from war
- Cosmetic services, supplies, and bonding applications
- Dietary devices or counseling
- Oral hygienic counseling services or plaque control programs
- Services or supplies that do not meet the insurance company's accepted standards of proper dental treatment
- Experimental services or supplies
- Periodontal splinting of teeth, except for temporary measures used to stabilize loose teeth (intra-coronal splinting)

TMJ

The McGraw-Hill Companies Dental Plan does not cover TMJ (temporomandibular joint syndrome), but coverage for TMJ may be provided through your medical care option.

- Reconstructive crowns, or fixed or removable dentures for treatment of face or jaw pains, such as temporomandibular joint (TMJ) syndrome (this may be covered under your medical option)
- Lost or stolen appliances
- Implants and related services
- Replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or adding teeth to any of these within five years after installation
- Precision attachments, unless they are required or complete a covered treatment
- Appliances, restorations, or procedures needed to alter the vertical dimensions or restore occlusion, or to splint or correct attrition or abrasion
- Drugs and medicines other than antibiotics and anesthetics administered by a dentist
- Other highly technical treatments

If you are not sure whether a particular treatment is covered, contact the plan administrator at 1-800-843-3661.

Pretreatment Estimates

If your dentist proposes costly or extensive dental treatment, you can find out in advance how much The McGraw-Hill Companies Dental Plan will pay by requesting a pretreatment estimate of costs. A pretreatment estimate is recommended when you are seeking dental care that is going to cost $300 or more. Based on the pretreatment estimate, you may be able to determine whether more cost-effective treatments are available.

To receive your pretreatment estimate, have your dentist submit a treatment plan in writing to the plan's insurance company, Aetna US Healthcare, for review. Aetna will review the plan and notify you and your dentist of how much the plan will pay. Based on the review, you'll be able to estimate your out-of-pocket expenses.

Other Coverage

The McGraw-Hill Companies Dental Plan has a coordination of benefits feature to prevent duplication of payments when you or your family members are covered by another group dental plan. The plans covered by the coordination feature include government coverage such as Medicare and medical coverage under the "no fault" or payment provisions of an automobile insurance contract. For more information, see "If You Have Other Coverage" in *Participating in Healthcare Coverage.*

Filing a Claim

Generally, you pay the full cost of your dental expense at the time you receive care, then submit a claim for reimbursement. (In some cases, you can have the plan reimburse your provider directly.) You must submit a separate claim form for each family member, but you can include more than one dental expense on each form.

You can print claim forms using The McGraw-Hill Companies Intranet, or online at *www.benefitsplanner.com*. You can also get them by calling the HRSC.

When you submit your claim, include a copy of the dentist's itemized bill and remember to keep a copy of both the claim and the bill for your records.

If you are not satisfied with the outcome of a claim you have submitted for benefits, you can ask that the claim be reviewed. See "Claims Review Process" in *Rules and Regulations* for information.

The DMO Dental Plan

The DMO Dental Plan is a managed care dental program with a nationwide network of dentists. The DMO is designed to provide all of your dental care through the dentists participating in the network. To receive benefits, you must see a participating provider.

To find out whether the DMO is available in your area...

call 1-800-THE-DMO1 (1-800-843-3661).

How the Plan Works

If you enroll for DMO coverage, you select a dentist who is part of the DMO network to serve as your primary dentist—known as your DMO dentist. Your DMO dentist is responsible for providing most of your dental care, and for referring you to specialists when necessary.

When you see your DMO dentist—or see a specialist following your DMO dentist's referral—the plan pays a percentage of the fees the dentist charges.

- Because the DMO network dentists provide care for pre-negotiated fees, you don't have to meet a deductible before the plan pays benefits, and you never have to worry about whether your dentist's charges will exceed the reasonable and customary costs of care.
- There are no annual or lifetime benefit limits for DMO care.

Selecting Your DMO Dentist

When you enroll, you select a DMO dentist for each person you are covering under the plan. You can choose the same DMO dentist for all of your family members, or each family member can choose a different DMO dentist—it's up to you. For a list of participating dentists, call 1-800-THE-DMO1 (1-800-843-3661), or visit *www.aetna.com/docfind*.

Changing Your DMO Dentist

You may change your DMO dentist at any time. To change your DMO dentist, contact the DMO Member Services Department at 1-800-THE-DMO1 (1-800-843-3661).

ID Cards

Soon after you enroll, you will receive an identification card for yourself and for each covered family member, listing the name and telephone number of your DMO dentist. When you schedule an appointment, state that you are covered by the DMO. At the dentist's office, you'll need to present your DMO ID card. If you lose your ID card, or if you need dental care before you receive your ID card, contact the DMO Member Services Department at 1-800-THE-DMO1 (1-800-843-3661).

What's Covered Under the DMO Dental Plan

To receive benefits from the DMO Dental Plan, your dental care must be provided by your DMO dentist. If you need to see a specialist, your DMO dentist must give you a referral or you will not receive benefits—even if the specialist participates in the DMO network.

Preventive Services

The DMO Dental Plan pays 100% of charges for these services, with no deductible or copayment:

- Routine exams (up to four visits a year)
- Cleanings and scalings (up to twice a year)
- Sealants (one per tooth every three years on permanent molars only)

- X-rays (bitewing X-rays limited to twice a year; full-mouth series limited to once every three years)
- Fluoride treatments (one course of treatment a year for children under age 18)
- Other preventive dental services

Basic Services

The DMO Dental Plan pays 100% of charges for these services with no deductible or copayment:

- Endodontic services (excluding molar root therapy)
- Fillings
- Oral surgery (including local anesthesia and routine post-operative care)
- Extractions
- Pulp capping
- Periodontal services (the plan pays 60% of charges for osseous surgery)
- Gingivectomy
- Emergency treatment for dental pain

Restorative Services

The plan pays 60% of charges for the following services with no deductible. You pay the remaining 40%:

- Adding teeth to an existing partial denture
- Crown and bridge repairs
- Crowns (including buildups when necessary)
- Dentures and partials (including adjustments within six months of installation)
- Full and partial denture repairs
- Gold inlays and onlays
- Posts and pontics
- Relining/rebasing dentures
- Stay plates
- Stress breakers
- Fixed or cemented appliance to correct habits
- Fixed space maintainers, band type
- Removable acrylic appliance with round clasp
- Removable appliance to correct habits
- Anesthesia for restorative services
- Osseous surgery
- Molar root canal therapy

Orthodontic Services

The plan pays 50% of charges for orthodontic services with no deductible. You pay the other 50%.

Emergency Care

If you need emergency care and are more than 50 miles from home, the DMO pays a limited benefit for treatment by any dentist (even if the dentist is not in the DMO network) to relieve pain or to prevent worsening of a condition that would result if treatment were delayed.

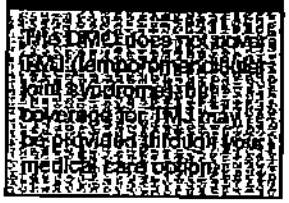
If you have an emergency near your home (within 50 miles), contact your DMO dentist. If your DMO dentist is unavailable, contact the DMO Member Services Department at 1-800-THE-DMO1 (1-800-843-3661). A representative will provide you with emergency guidelines and procedures.

What's Not Covered Under the DMO Dental Plan

The DMO Dental Plan does not cover the following treatments and services:

- Services not reasonably necessary or customarily performed
- Services performed by a dentist who is not part of the DMO network, except in an emergency
- Services considered solely cosmetic in nature, including facings on crowns or pontics that are behind the second bicuspid (unless they are needed due to accidental injuries sustained while the patient is covered by the plan)
- Services not performed by a dentist (excluding work performed by a licensed dental hygienist under the direction of a dentist)
- Initial placement of a partial or fully removable denture, removable bridge, or fixed bridgework if it includes replacement of one or more natural teeth missing before the patient became covered under the DMO Dental Plan, unless it also includes replacement of a natural tooth that:
  - is removed while the patient is a covered by the plan, and
  - was not an abutment to a partial denture, removable bridge or fixed bridge installed during the prior five years
- Replacement or modification of a partial or fully removable denture, removable bridge, fixed bridgework (or for adding teeth to any of these), crown, or gold restoration within five years after installation
- Gold crowns or restorations, unless:
  - treatment is for a decay or traumatic injury, and teeth cannot be restored with a filling material, or
  - the tooth is an abutment to a covered partial denture or fixed bridge
- Replacement of lost or stolen appliances
- Appliances or restorations needed to alter the vertical dimensions, to restore occlusion, or to splint or correct attention or abrasion
- Treatment for problems of the jaw joint, including temporomandibular joint (TMJ) syndrome (this may be covered under your medical option), craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull, and of the complex of muscles, nerves, and other tissues related to that joint

TMJ



- Charges for treatment that began before the patient became covered by the DMO Dental Plan (special rules apply for orthodontic care)
- Charges for services already covered by another plan, including Workers' Compensation
- Charges for services provided under any other program affiliated with the corporation
- Charges for services above the usual charge made by the providers for the service when there is no insurance
- Charges for services that exceed the plan benefit for covered dental expenses, as listed under "What's Covered Under the DMO Dental Plan."

If you are not sure whether a particular treatment is covered, contact the plan administrator at 1-800-THE-DMO1 (1-800-843-3661).

Other Coverage

The DMO Dental Plan has a coordination of benefits feature to prevent duplication of payments when you or your family members are covered by another group dental plan. The plans covered by the coordination feature include government coverage such as Medicare and medical coverage under the "no fault" or payment provisions of an automobile insurance contract. For more information, see "If You Have Other Coverage" in *Participating in Healthcare Coverage.*

Filing a Claim

You don't need to file claims when you use your DMO dentist for your dental services. Your DMO dentist files all claims directly with the insurance company.

If your DMO dentist bills you directly for covered services, call the DMO Member Services Department at 1-800-THE-DMO1 (1-800-843-3661). A representative will instruct you on how to file a claim.

Vision Coverage

You can save money on your eye care needs if you enroll in The McGraw-Hill Companies Vision Plan. This plan, administered by Vision Service Plan (VSP), gives you access to a nationwide network of vision care professionals.

Your medical plan might also include benefits for certain types of vision care. Check the plan summaries at *www.benefitsplanner.com* for details.

Find VSP Providers

To find out which vision care providers in your area participate in the VSP network:

- Call VSP at 1-800-VSP-7195 (1-800-877-7195).
- Visit *www.vsp.com*.

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How the Plan Works

The Vision Plan covers services and materials from providers and eyewear facilities that participate in the Vision Service Plan (VSP) network. The VSP network operates throughout the United States and in Puerto Rico. The plan does not cover services or materials from providers and eyewear facilities that are not part of the VSP network.

Certain services, such as an eye exam every 12 months, are paid in full, while the cost of other services, such as cosmetic contact lenses, are discounted. There are limits on how often you can receive benefits.

To find your costs for coverage, see the plan summaries at *www.benefitsplanner.com*.

For More Information

You can learn more about the VSP network on The McGraw-Hill Companies Intranet and at *www.benefitsplanner.com*, or by contacting VSP directly:

- by phone, at 1-800-VSP-7195 (1-800-877-7195),
- via the Internet, at *www.vsp.com*, or
- via e-mail, at member@vsp.com.

Filing a Claim

You do not need to file claim forms to receive vision care benefits. Your VSP-participating provider submits the necessary paperwork directly to VSP for reimbursement, so there is no paperwork for you to complete.

Finding a VSP Provider

To find a VSP-participating provider in your area:

- Call VSP at 1-800-VSP-7195 (1-800-877-7195).

- Visit *www.vsp.com*.
- E-mail VSP at member@vsp.com.
- Access VSP through The McGraw-Hill Companies Intranet.

You don't have to use the same provider for all your vision care needs; you can choose a different provider each time you need care.

To locate a VSP doctor who participates in the laser vision correction surgery program:

- Call 1-888-354-4434.
- Visit *www.vsp.com*.

Using the Plan

Getting More for Your Vision Care Dollars

Don't forget that you may be able to use a Healthcare FSA to help pay for any vision expenses that are not covered by the vision or other healthcare plans.

Here's how to use the Vision Plan:

- Call your VSP provider for an appointment and identify yourself as a VSP member. Be ready to provide your identification number (usually your Social Security number), the corporation name, and your date of birth.
  - When a covered family member schedules an eye exam, he or she needs to provide your name and Social Security number, the corporation name, and his or her own name and date of birth.
- After you schedule an appointment, your VSP provider contacts VSP to verify your eligibility and coverage, and to obtain authorization for services and materials. If you are not eligible for benefits at that time (for example, if your last eye exam covered by VSP was less than a year ago), your provider will let you know.
- Your provider performs an exam and prescribes and orders eyewear, if necessary. If eyewear is necessary, your provider coordinates with a VSP-approved contract laboratory. Your provider also itemizes any noncovered charges and has you sign a form to verify that services were performed.

There is no copayment or other cost to you unless you choose a cosmetic option, exceed the plan maximums, or select services or materials that are not covered.

What's Covered

Eligible services and materials from a VSP provider are covered as shown in the chart below. To receive these benefits, vision care services must be performed by a participating eye care professional.

Service	Benefit	Frequency (from your last date of service)
Exams	Paid in full. ▪ Includes tests to determine the need for corrective lenses ▪ The components of the eye examination include external and internal examination, including direct and/or indirect ophthalmoscopy, refractive evaluation, binocular function tests, and diagnosis and treatment plan	Once every 12 months.

Service	Benefit	Frequency (from your last date of service)
Eyeglass lenses	Paid in full. ▪ Single vision, bifocal, trifocal, or lenticular lenses	Once every 12 months.
Frames	Covered up to $145. If you select frames that exceed the plan's retail cost limit, you pay a portion of the difference. The plan will then provide a 20% discount on the cost in excess of $145.	Available once every 24 months.
Contact lenses	A $105 allowance is applied to the professional fees (e.g., further evaluation, fitting fees, material costs, follow-up care, etc.) for elective contact lenses in place of frames and lenses. ▪ As an added benefit, participants receive a 15% discount off the professional services associated with contact lenses.	Once every 12 months.
Low vision ("partially sighted") services	You are eligible for benefits such as supplemental testing, low vision prescription services, evaluations, optical and non-optical aids, and training. 75% of the cost is covered, up to $1,000 every two years. Prior authorization is required.	Once every two calendar years.
Eyewear discounts	You receive a 20% discount on additional pairs (lenses and frames) of prescription eyeglasses with any eyeglass lens options. You receive a 15% discount on related professional services if you choose elective contact lenses.	Must be used within 12 months following the covered eye exam and must be used with the VSP provider who provided the exam.
Laser vision correction	A discount for laser surgery when obtained through VSP-contracted doctors, surgeons, and laser centers. ▪ This program includes the two most common laser vision correction procedures, laser-assisted in-situ keratomileusis (LASIK) and photorefractive keratectomy (PRK).	Not applicable.
Cosmetic options	You can save approximately 15% – 20% off the reasonable and customary charge for selected cosmetic options, such as blended bifocal lenses and special UV coatings.	Not applicable.

Eye Care Professionals

To receive many of the benefits described above, the services must be performed by a participating eye care professional. Eye care professionals are defined as follows:

- Ophthalmologist—a licensed physician who specializes in the diagnosis and treatment of eye conditions, performs eye surgery and vision exams, and prescribes lenses to improve vision
- Optometrist—a doctor of optometry who is specifically trained to examine the eye for vision problems and disease, perform vision exams, and prescribe lenses
- Optician—a technician legally qualified to supply eyeglasses according to a prescription written by an ophthalmologist or optometrist
- Optometric technician assistant—a person trained to assist in vision testing, provide frame styling services, instruct patients in contact lens handling, and perform other related duties under the supervision of an ophthalmologist or optometrist

What's Not Covered

The Vision Plan does not cover the following:

- Services or materials from providers and eyewear facilities that are not part of the VSP network.
- Services and materials obtained more often than the plan's normal frequency intervals allow.
- Services and materials whose costs exceed the plan allowance.
- Eye care treatment, such as cataracts, infections, and injuries. (The Vision Care Plan only covers services and materials for correcting vision. Your medical plan may cover eye care treatment.)

For More Information

You can call VSP at 1-800-VSP-7195 (1-800-877-7195) to speak with a customer service representative Monday through Friday from 9:00 a.m. to 9:00 p.m., Eastern Time. After hours and on weekends, you can use the interactive voice response system to:

- verify eligibility,
- check plan coverage,
- confirm a provider's participation in the VSP network, and
- request that a list of participating providers be sent to you.

You can also contact VSP:

- via the Internet at *www.vsp.com*,
- via e-mail at member@vsp.com, where a customer service representative responds to your request, or
- via The McGraw-Hill Companies Intranet.

Retiree Healthcare Coverage

If you are eligible, you can receive corporation-provided medical, dental, and vision coverage at retirement through the corporation's Group Health Plan for Retirees.

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Eligibility

If you are enrolled in corporation-provided medical, dental, or vision coverage when you retire, you can enroll for that same type of coverage if you meet one of the following requirements:

- You are age 55 or older with at least 10 years of continuous service and are eligible for a pension (ERP) benefit from the corporation.
- You are age 50 or older with at least 20 years of continuous service and are terminated through no fault of your own.

Your Family Members

If you are covering any eligible family members on the day before you retire, you may continue their coverage if you enroll for retiree coverage. In most cases, they must be enrolled for the same coverage you choose, but exceptions may apply if a family member is eligible for Medicare coverage and you are not, or vice versa. See "Retiree Medical Coverage Options" for details.

Your Family Members

If your family members are eligible for coverage, they must generally be enrolled for the same coverage that you elect. If, however, a family member is eligible for Medicare and you are not (or vice versa), special rules apply.

Individuals eligible for Medicare may choose only from the coverage described in "Medical Coverage at Age 65 or Older."

COBRA

If you do not meet the eligibility requirements for corporation retiree medical, dental, or vision coverage, you may continue your corporation-provided healthcare coverage under a federal law known as COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985. (Your enrolled family members may also continue their coverage.) However, COBRA coverage is not available for you or anyone in your family who is eligible for Medicare. If you continue coverage under COBRA, it is at your expense and for a specified period of time. See *COBRA Health Coverage* for details.

Retiree Medical Coverage Options

The type of retiree medical coverage available to you depends on your age.

Medical Coverage Before Age 65

There are three medical options available to eligible retirees who are younger than 65 when they retire:

- Health Maintenance Organizations (HMO)—If an HMO is available in your area, you can choose this option.
- Point-of-Service (POS) Plan—If an HMO is not available in your area, you may choose POS plan coverage. You may also "buy up" to POS plan coverage if both an HMO and the POS plan are available in your area.
- The McGraw-Hill Companies Modified Medical Plan (traditional indemnity plan)—If you live in an area where there is no HMO or POS coverage offered by McGraw-Hill, you can enroll in The McGraw-Hill Companies Modified Medical Plan.

Health Maintenance Organizations (HMOs)

You may enroll in an HMO if you are under age 65 and if this option is offered in your area. HMOs provide healthcare services to participants through a network of medical care facilities and doctors. Generally, when you join an HMO, you must use the providers and facilities affiliated with that HMO in order to receive benefits. See *Health Maintenance Organizations (HMOs)* for more information.

If you live in an area where both a POS plan and an HMO are offered, you have the option to enroll in the POS plan, but you'll pay an additional amount each month for that POS coverage. For 2004, the additional monthly charge is $65 per person per month in addition to the contributions you would have to pay for coverage without the POS buy up.

Point-of-Service (POS) Plan

If you live in an area where the corporation does not offer an HMO option, you can enroll in the UnitedHealthcare POS Plan and pay the standard retiree monthly medical contribution amount. If you live in an area where both the POS plan and an HMO are available, you can buy up to the POS. The buy up covers the price differential between an HMO and the POS plan. For 2004, the additional monthly charge is $65 per month for each covered individual. In other words, if you choose the buy-up option, you will pay $65 per person per month in addition to the contributions you would have to pay for coverage without the POS buy up.

See *Point-of-Service (POS) Plan* for more information on how the POS plan works.

The McGraw-Hill Companies Modified Medical Plan

The McGraw-Hill Companies Modified Medical Plan, a traditional indemnity plan, is offered to retirees under age 65 in areas where the corporation does not offer an HMO or POS plan option.

How the Plan Works

The plan provides coverage for a broad range of hospital, medical, and surgical expenses. Under The McGraw-Hill Companies Modified Medical Plan, you may use any medical provider. After you satisfy an annual deductible, the plan reimburses you 80% of the reasonable and customary charges for covered expenses.

Separate Vendors for Special Services

For some of the HMOs and the POS plan, a separate vendor may be responsible for some of the specialized services. For example, some of the medical options provide prescription drug benefits through Medco Health and mental health and chemical dependency care through ValueOptions. For details on the medical coverage options available to you, see the plan summaries at *www.benefitsplanner.com* or the *Healthcare Option Summaries*.

Deductible

The annual deductible is the amount you and each family member must pay for covered medical expenses before the plan pays benefits. An individual deductible applies separately to you and to each of your covered family members. A new deductible applies each calendar year. When you satisfy the annual deductible requirement, the plan reimburses a percentage of covered expenses.

The following chart lists the 2004 deductibles for the Modified Medical Plan.

Annual Salary*	Individual/Family Deductible
less than $35,000	$200/$400
$35,000–$69,999	$300/$600
$70,000–$149,999	$400/$800
$150,000 or more	$500/$1,000

** Note that this is not your pension. It is your salary as of the last day you were an active employee.*

Coinsurance

Once you meet the deductible, the plan pays 80% of the reasonable and customary charges for most medical expenses, including hospitalization, doctor's office visits, surgeon's fees, and prescription drugs. The remaining percentage that you pay – 20% – is called your coinsurance.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you and your family pay for covered expenses each year. Essentially, the out-of-pocket maximum protects you against having to pay extraordinary bills in a given year. Once your share of covered expenses reaches the out-of-pocket maximum, the plan pays 100% of the eligible charges for any additional covered expenses for the rest of the calendar year.

The following chart lists the 2004 out-of-pocket maximums for the Modified Medical Plan.

Annual Salary*	Individual/Family Deductible
less than $35,000	$2,000
$35,000–$69,999	$3,000
$70,000–$149,999	$4,000
$150,000 or more	$5,000

** Note that this is not your pension. It is your salary as of the last day you were an active employee.*

The out-of-pocket maximum applies separately to you and each of your dependents. The following costs do not count toward the out-of-pocket maximum:

- Deductibles
- Prescription drug charges
- Mental health/chemical dependency charges
- Charges for noncertified hospital stays
- Expenses over the reasonable and customary charge
- Expenses not covered by the plan